

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03521

Reg. Dist. No. 4

1. PLACE OF DEATH
a. COUNTY

Allegany

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL
and give nearest town)

Cumberland

c. LENGTH OF STAY IN 1b

6 yrs

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

Sacred Heart Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)

a. STATE

Md.

b. COUNTY

Allegany

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Cumberland

d. STREET ADDRESS

45 Marion St.

e. IS RESIDENCE
ON A FARM?YES NO 3. NAME OF
DECEASED
(Type or print)First
OliveMiddle
ELast
Ambrose4. DATE
OF
DEATH

Apr 1957

9

19 57

5. SEX

6. COLOR OR RACE

7. MARRIED NEVER MARRIED

8. DATE OF BIRTH

9. AGE (In years
last birthday)

10. IF UNDER 1 YEAR

11. IF UNDER 24 HRS.

Female

white

WIDOWED DIVORCED

June 4, 1885

71

yr.

Months

Days

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work done
during most of working life, even if retired)

Housewife

10b. KIND OF BUSINESS OR INDUSTRY

Own Home

11. BIRTHPLACE (State or foreign country)

Hancock, Md.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Edward Brady

14. MOTHER'S MAIDEN NAME

Susan Craig

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unknown)
If yes, give war or dates of service)

no

16. SOCIAL SECURITY NO.

none

17. INFORMANT

(daughter) Edith A. Heller, Cumberland, Md.

Address

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

Myocardial failure

INTERVAL BETWEEN
ONSET AND DEATH

sudden

432.1

DUE TO

Conditions, if any, which
gave rise to Immediate cause
(a), stating the underlying
cause last.

(b)

Chronic myocarditis

also had

?

DUE TO

(c)

Arteriosclerosis

?

MEDICAL CERTIFICATION

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY
PERFORMED?YES NO 20a. EXTERNAL CAUSE WAS
PRIMARY OR CONTRIBUTING
CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY
Month, Day, Year
Hour
o. m.
p. m.20d. INJURY OCCURRED
While
at work Not while
at work 20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I took charge of the remains described above, held on Autopsy Inspection Inquiry and find that death resulted from: Natural causes Accident Suicide Homicide Undetermined cause ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

H. V. Deming M.D.

M.D. CHIEF MEDICAL EXAMINER ASSISTANT MEDICAL EXAMINER DEPUTY MEDICAL EXAMINER

DATE SIGNED

April 9, 1957

22a. BURIAL, CREMATION,
REMOVAL (Specify)
Burial

22b. DATE THEREOF

April 13, 1957

22c. NAME OF CEMETERY OR CREMATORIUM

Rose Hill Cemetery

22d. LOCATION (City, town, or county)

(State)

Cumberland, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

James F. Scarpelli, Cumberland, Maryland.

24a. REC'D BY REGISTRAR

D.O.A.

24b. REGISTRAR'S SIGNATURE

April 12, 1957 W.R. Frank M.D.

BUREAU V. 8

APR 15 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3585

CERTIFICATE OF DEATH

13523

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Allegany		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland, rural		c. LENGTH OF STAY IN 1b years 10 d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 293 National Highway		
3. NAME OF DECEASED (Type or print) John		First Reid	Middle Anderson	
4. DATE OF DEATH April 26		Month 19	Day 57	
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH December 16, 1865		9. AGE (In years lost birthday) 91	10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Store Mgr.	11. BIRTHPLACE (State or foreign country) Bellshill, Lanarkshire	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME John Anderson		14. MOTHER'S MAIDEN NAME Reid Margaret Reid		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	17. INFORMANT Wilfred R. Anderson, La Vale, Maryland	Address
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		INTERVAL BETWEEN ONSET AND DEATH Hypertension Heart disease Scars		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED White Nat white at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 850 M	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>April 26, 1957</u> to <u>April 27, 1957</u> , that I last saw the deceased alive on <u>April 26, 1957</u> , and that death occurred at <u>850 M</u> , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) F. Alan G. Murray, M.D.		DATE SIGNED April 28, 1957
ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) F. Alan G. Murray, M.D.				
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/29/57	22c. NAME OF CEMETERY OR CREMATORIUM Hillcrest Burial Park	22d. LOCATION (City, town, or county) Cumberland, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer, Cumberland, Maryland		ADDRESS	24a. REC'D BY REGISTRAR W.R. Frank, M.D.	24b. REGISTRAR'S SIGNATURE

CERTIFICATE OF DEATH

RECEIVED
APR 30 1957
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
352 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **103524**

1. PLACE OF DEATH a. COUNTY Allegany		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Md. b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN b 60 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Memorial Hospital		d. STREET ADDRESS 510 Baltimore Ave.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First JOHN	Middle HENRY	Last BARRETT
4. DATE OF DEATH April 14 1957	Month Day Year	Month Day Year	Month Day Year
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1886 Dec. 21-1888
9. AGE (In years last birthday) 70 68 yrs.		10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Welder		10b. KIND OF BUSINESS OR INDUSTRY B&O.R.Ry.	
11. BIRTHPLACE (State or Foreign country) Pa.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Samuel Barrett		14. MOTHER'S MAIDEN NAME Emma Sellers	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes - 1908-1911-Mexican		16. SOCIAL SECURITY NO. 17. INFORMANT Mr. Jerald Barrett, Glencoe, Penna.	
18. CAUSE OF DEATH Borden Patrol (Indicate for (a), (b), and (c).)		Address	
PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) 420.1		INTERVAL BETWEEN ONSET AND DEATH	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		Myocardial failure	
DUE TO (b)		Hypertensive cardio-vascular disease	
DUE TO (c)		with coronary insufficiency.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
92.6 Intertrochanteric fracture of left femur.			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part II, Part III, if item 18) Step and fell to concrete, injured left hip. Comming out of Am. Legion Bldg. in Ridgely W. Va.	
20c. TIME OF INJURY Month, Day, Year Hour 11.30 p.m. Dec. 15 1956		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Am Legion Bldg. Ridgely Mineral W. Va.		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>			
ACTUAL SIGNATURE H.V. Deming M.D.		DATE SIGNED April 14-1957	
EXAMINER'S NAME (Type) H.V. Deming M.D.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF April 17, 1957	
22c. NAME OF CEMETERY OR CREMATORIUM Rose Hill Cemetery		22d. LOCATION (City, town, or county) (State) Cumberland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Silcox Funeral Home, Cumberland, Maryland.		24a. REC'D BY REGISTRAR DATE April 16, 1957 W.R. Frantz, M.D.	
ADDRESS		24b. REGISTRAR'S SIGNATURE	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar prior to burial, cremation, or removal.

REGELIVE
BUREAU V. S.

APR 18 1957

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Within corporate limits

03525

3522

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH a. COUNTY ALLEGANY		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND, MD.		b. COUNTY ALLEGANY	
c. LENGTH OF STAY IN 16 7 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL MEMORIAL & WARWICK AVES.		d. STREET ADDRESS 50 WEMPE DRIVE	
3. NAME OF DECEASED (Type or print) JOHN		4. DATE OF DEATH Month APRIL Day 1 Year 1957	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JANUARY 3, 1869
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Custodian		10b. KIND OF BUSINESS OR INDUSTRY Newspaper Office	11. BIRTHPLACE (State or foreign country) CUMBERLAND, MD.
13. FATHER'S NAME LEOPOLD BERKENBAUGH		14. MOTHER'S MAIDEN NAME SARAH ROWAN	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 216-22-6071	
17. INFORMANT Miss Sadie Berkenbaugh, 50 Wempe Dr.,		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 490X		INTERVAL BETWEEN ONSET AND DEATH 7 days	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO (c)		Lobar Pneumonia - left Hypertension, Cardio Vascular Disease Advanced Age.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) M.D. 133 Virginia Ave, Cumberland, MD	(County) Cumberland, Md. (State)
21. I certify that I attended the deceased from March , 19 57 , to April , 19 57 , that I last saw the deceased alive on April 1 , 19 57 , and that death occurred at 1:40 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>G. O. Himmelwright</i>	ADDRESS (Street, city or town, state) 133 Virginia Ave, Cumberland, MD DATE SIGNED 4/2/57		
PHYSICIAN'S NAME (Type) G. O. Himmelwright, M.D.		22d. LOCATION (City, town, or county) Cumberland, Md. (State)	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF April 4, 1957	22c. NAME OF CEMETERY OR CREMATORIAL St. Mary's Cem.	22d. LOCATION (City, town, or county) Cumberland, Md. (State)
23. FUNERAL DIRECTOR'S SIGNATURE <i>Hager Funeral Home</i>		ADDRESS Trustline REC'D BY REGISTRAR DATE April 4, 1957 24b. REGISTRAR'S SIGNATURE J.R. Frantz, M.D.	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 1 may be reigned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit Permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Y 721

Y 371

Y 721

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BUREAU V. S

APR 5 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

103526

DR. WEISMAN

3523

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH a. COUNTY ALLEGANY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND		b. COUNTY ALLEGANY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 4 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FROSTBURG		d. STREET ADDRESS 119 W. MAIN ST.		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) ANNA ROSE		First	Middle	Last	4. DATE OF DEATH APRIL 7 1957	Month	Day	Year
5. SEX FEMALE		6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JUNE 12, 1865	9. AGE (In years last birthday) 91	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days	12. IF UNDER 24 HRS Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Avilton, Maryland		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME NOAH GARLITZ		14. MOTHER'S MAIDEN NAME MC KENZIE, MARTHA						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT MEMORIAL HOSPITAL		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0		DUE TO ② Cerebral Infarction		① RESPIRATORY FAILURE		INTERVAL BETWEEN ONSET AND DEATH #1 instantly		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. ③ Cerebral Atherosclerosis		DUE TO ④ Atherosclerotic Heart Disease				#2 1 week #3 5 years		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						#4 unknown		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 59 Green St		20f. (City or town) Garrett County, Maryland		(County) (State)
21. I certify that I attended the deceased from 4/7 1957 to 4/7 1957 that I last saw the deceased alive on 4/7 1957 , and that death occurred at 11:22 PM , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) Cumberland, Md						
ACTUAL SIGNATURE DR. WEISMAN		DATE SIGNED 4/9/57						
PHYSICIAN'S NAME (Type) DR. WEISMAN								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF April 10, 1957		22c. NAME OF CEMETERY OR CREMATORIUM Robeson Cemetery		22d. LOCATION (City, town, or county) Garrett County, Maryland		
23. FUNERAL DIRECTOR'S SIGNATURE Durst Funeral Home, Frostburg, Maryland.		ADDRESS		24a. REC'D BY REGISTRAR DR. WEISMAN		24b. REGISTRAR'S SIGNATURE W.R. Frosty, M.D.		

DEPARTMENT OF HOMELAND SECURITY

CERTIFICATE OF DEATH

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49	50	51	52	53	54	55	56	57	58	59	60	61	62	63	64	65	66	67	68	69	70	71	72	73	74	75	76	77	78	79	80	81	82	83	84	85	86	87	88	89	90	91	92	93	94	95	96	97	98	99	100	101	102	103	104	105	106	107	108	109	110	111	112	113	114	115	116	117	118	119	120	121	122	123	124	125	126	127	128	129	130	131	132	133	134	135	136	137	138	139	140	141	142	143	144	145	146	147	148	149	150	151	152	153	154	155	156	157	158	159	160	161	162	163	164	165	166	167	168	169	170	171	172	173	174	175	176	177	178	179	180	181	182	183	184	185	186	187	188	189	190	191	192	193	194	195	196	197	198	199	200	201	202	203	204	205	206	207	208	209	210	211	212	213	214	215	216	217	218	219	220	221	222	223	224	225	226	227	228	229	230	231	232	233	234	235	236	237	238	239	240	241	242	243	244	245	246	247	248	249	250	251	252	253	254	255	256	257	258	259	260	261	262	263	264	265	266	267	268	269	270	271	272	273	274	275	276	277	278	279	280	281	282	283	284	285	286	287	288	289	290	291	292	293	294	295	296	297	298	299	300	301	302	303	304	305	306	307	308	309	310	311	312	313	314	315	316	317	318	319	320	321	322	323	324	325	326	327	328	329	330	331	332	333	334	335	336	337	338	339	340	341	342	343	344	345	346	347	348	349	350	351	352	353	354	355	356	357	358	359	360	361	362	363	364	365	366	367	368	369	370	371	372	373	374	375	376	377	378	379	380	381	382	383	384	385	386	387	388	389	390	391	392	393	394	395	396	397	398	399	400	401	402	403	404	405	406	407	408	409	410	411	412	413	414	415	416	417	418	419	420	421	422	423	424	425	426	427	428	429	430	431	432	433	434	435	436	437	438	439	440	441	442	443	444	445	446	447	448	449	450	451	452	453	454	455	456	457	458	459	460	461	462	463	464	465	466	467	468	469	470	471	472	473	474	475	476	477	478	479	480	481	482	483	484	485	486	487	488	489	490	491	492	493	494	495	496	497	498	499	500	501	502	503	504	505	506	507	508	509	510	511	512	513	514	515	516	517	518	519	520	521	522	523	524	525	526	527	528	529	530	531	532	533	534	535	536	537	538	539	540	541	542	543	544	545	546	547	548	549	550	551	552	553	554	555	556	557	558	559	560	561	562	563	564	565	566	567	568	569	570	571	572	573	574	575	576	577	578	579	580	581	582	583	584	585	586	587	588	589	590	591	592	593	594	595	596	597	598	599	600	601	602	603	604	605	606	607	608	609	610	611	612	613	614	615	616	617	618	619	620	621	622	623	624	625	626	627	628	629	630	631	632	633	634	635	636	637	638	639	640	641	642	643	644	645	646	647	648	649	650	651	652	653	654	655	656	657	658	659	660	661	662	663	664	665	666	667	668	669	670	671	672	673	674	675	676	677	678	679	680	681	682	683	684	685	686	687	688	689	690	691	692	693	694	695	696	697	698	699	700	701	702	703	704	705	706	707	708	709	710	711	712	713	714	715	716	717	718	719	720	721	722	723	724	725	726	727	728	729	730	731	732	733	734	735	736	737	738	739	740	741	742	743	744	745	746	747	748	749	750	751	752	753	754	755	756	757	758	759	760	761	762	763	764	765	766	767	768	769	770	771	772	773	774	775	776	777	778	779	770	771	772	773	774	775	776	777	778	779	780	781	782	783	784	785	786	787	788	789	790	791	792	793	794	795	796	797	798	799	800	801	802	803	804	805	806	807	808	809	8010	8011	8012	8013	8014	8015	8016	8017	8018	8019	8020	8021	8022	8023	8024	8025	8026	8027	8028	8029	8030	8031	8032	8033	8034	8035	8036	8037	8038	8039	8040	8041	8042	8043	8044	8045	8046	8047	8048	8049	8050	8051	8052	8053	8054	8055	8056	8057	8058	8059	8060	8061	8062	8063	8064	8065	8066	8067	8068	8069	8070	8071	8072	8073	8074	8075	8076	8077	8078	8079	8080	8081	8082	8083	8084	8085	8086	8087	8088	8089	8090	8091	8092	8093	8094	8095	8096	8097	8098	8099	80100	80101	80102	80103	80104	80105	80106	80107	80108	80109	80110	80111	80112	80113	80114	80115	80116	80117	80118	80119	80120	80121	80122	80123	80124	80125	80126	80127	80128	80129	80130	80131	80132	80133	80134	80135	80136	80137	80138	80139	80140	80141	80142	80143	80144	80145	80146	80147	80148	80149	80150	80151	80152	80153	80154	80155	80156	80157	80158	80159	80160	80161	80162	80163	80164	80165	80166	80167	80168	80169	80170	80171	80172	80173	80174	80175	80176	80177	80178	80179	80180	80181	80182	80183	80184	80185	80186	80187	80188	80189	80190	80191	80192	80193	80194	80195	80196	80197	80198	80199	80200	80201	80202	80203	80204	80205	80206	80207	80208	80209	80210	80211	80212	80213	80214	80215	80216	80217	80218	80219	80220	80221	80222	80223	80224	80225	80226	80227	80228	80229	80230	80231	80232	80233	80234	80235	80236	80237	80238	80239	80240	80241	80242	80243	80244	80245	80246	80247	80248	80249	80250	80251	80252	80253	80254	80255	80256	80257	80258	80259	80260	80261	80262	80263	80264	80265	80266	80267	80268	80269	80270	80271	80272	80273	80274	80275	80276	80277	80278	80279	80280	80281	80282	80283	80284	80285	80286	80287	80288	80289	80290	80291	80292	80293	80294	80295	80296	80297	80298	80299	80300	80301	80302	80303	80304	80305	80306	80307	80308	80309	80310	80311	80312	80313	80314	80315	80316	80317	80318	80319	80320	80321	80322	80323	80324	80325	80326	80327	80328	80329	80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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

03527

CERTIFICATE OF DEATH

3524

Reg. Dist. No. 4

1. PLACE OF DEATH

COUNTY ALLEGANY

CITY (If outside corporate limits, write RURAL
OR
end give nearest town)

TOWN CUMBERLAND

MARYLAND

LENGTH OF STAY
(In this place)

5 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED

STATE MARYLAND

COUNTY ALLEGANY

CITY (If outside corporate limits, write RURAL and give nearest town)

TOWN CUMBERLAND

STREET ADDRESS
(If rural give location)

109 DECATUR ST.

3. NAME OF
DECEASED
(Type or Print)

CATHERINE

R.

BOLINGER

5. SEX

6. COLOR OR
RACE

FEMALE

WHITE

10a. USUAL OCCUPATION (Give kind of work
done during most of working life, even if
retired)

Housewife

10b. KIND OF BUSINESS
OR INDUSTRY

Own Home

13. FATHER'S NAME

AUGUST HAHNE

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unk.)

(If Yes, give war or dates of service)

NO

16. SOCIAL SECURITY NO.

none

17. INFORMANT & ADDRESS

DAUGHTER MRS. BOYCE, 109 DECATUR ST.

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

X IMMEDIATE CAUSE

(A) Squamous cell Ca of uterine cervix

INTERVAL BETWEEN
ONSET AND DEATH

12 mos

ANTECEDENT CAUSE(S) DUE TO

DISEASES OR CONDITIONS, IF ANY, (B)
GIVING RISE TO THE ABOVE CAUSE
STATING UNDERLYING CAUSE LAST. DUE TO
(C)

18. MEDICAL CERTIFICATION

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION

Sept. 1956

19b. MAJOR FINDINGS OF OPERATION

Extension of Ca into uterus

20. AUTOPSY?

YES NO 21a. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF DEATH
(If either, NOTIFY MEDICAL EXAMINER)21b. PLACE (Home, farm, factory,
OF INJURY street, office bldg., etc.)

21c. WHERE DID INJURY OCCUR? (City or town)

(County)

(State)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)

M.

21e. INJURY OCCURRED
While
at work Not while
at work

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 4-20, 19-57, to 4-25, 19-57, that I last saw the deceased

alive on 4-25, 19-57, and that death occurred at 6 p. M., from the causes and on the date stated above.

SIGNATURE

Raelyn B. Bocci

M.D.

ADDRESS (Street, city, town, state)

DATE SIGNED

23. BURIAL, CREMATION,
REMOVAL (SPECIFY)
Burial

DATE THEREOF

4-28-1957

NAME OF CEMETERY OR CREMATORI

Rose Hill Cemetery

LOCATION (City, town, or county)

(State)

24. REC'D BY REGISTRAR

REGISTRAR'S SIGNATURE

April 27, 1957 Winter R. Frank, M.D. James F. Scarpelli, Cumberland, Md.

RECEIVED
BUREAU V. S.

APR 20 1944

13528

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Within corporate limits

Reg. Dist. No. 4

3525

1. PLACE OF DEATH a. COUNTY Allegany				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Md. b. COUNTY Allegany				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN lb 11 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		d. STREET ADDRESS 112 Decatur St.		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Sacred Heart Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF -DECEASED (Type or print)		First George	Middle R	Last Bramble	4. DATE OF DEATH April 13 1957	Month April	Day 13	Year 1957
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 24-1874	9. AGE (in years last birthday) 82 yrs	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	12. IF UNDER 24 HRS. Hours 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Freight Agent		10b. KIND OF BUSINESS OR INDUSTRY B&O R.R.		11. BIRTHPLACE (State or foreign country) Folks Mills, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME John T. Bramble				14. MOTHER'S MAIDEN NAME Eliza A. Rice				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT (wife) Elizabeth Bramble, Cumberland, Md.		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial failure DUE TO 4420.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Sclerotic heart disease DUE TO (c) ?								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Comminuted intertrochanteric fracture of left femur.								
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of itself) fell to the floor. Descending cellar steps, missed last step, lost balance &						
20c. TIME OF INJURY Hour 6.30 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) Cumberland, Allegany, Md.		(County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>								
ACTUAL SIGNATURE EXAMINER'S NAME (Type) H. V. Deming M.D.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> April 14-1957						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF April 16, 1957		22c. NAME OF CEMETERY OR CREMATORIUM Hillcrest Burial Park		22d. LOCATION (City, town, or county) Cumberland, Maryland		
23. FUNERAL DIRECTOR'S SIGNATURE Louis Stein, Inc., Cumberland, Maryland.		ADDRESS 24a. REG'D BY REGISTRAR April 16, 1957 W. R. Frank, M.D. 24b. REGISTRAR'S SIGNATURE						

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU V. S.

APR 2 1944

REGEL V. FEL

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03529

3573

CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH a. COUNTY Allegany		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg		b. COUNTY Allegany	
c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lonaconing	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Miners Hospital		d. STREET ADDRESS Beachwood Street	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Ida	Middle Bell	Last Broadwater
4. DATE OF DEATH	Month April	Day 1	Year 1957
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 12, 1876
9. AGE (In years from birth to death) 80 yrs.		10. IF UNDER 1 YEAR, IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Garrett County, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Levi Bittinger		14. MOTHER'S MAIDEN NAME Rebecca Nobil	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. none	
17. INFORMANT Charles Broadwater		Address Frostburg, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: 2011 IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		"Son" Cerebral Vascular Accident 3 mos.	
(b) DUE TO Essential Hypertension		years	
(c) Atherosclerosis - Diabetes Mellitus		years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July 16, 1956</u> to <u>April 1, 1957</u> , that I last saw the deceased alive on <u>March 31, 1957</u> , and that death occurred at <u>4:30 AM</u> , from the causes and on the date stated above. ACTUAL SIGNATURE <u>Leslie R. Miles</u> I.M.D. ADDRESS (Street, city or town, state) MAIN ST		DATE SIGNED	
PHYSICIAN'S NAME (Type) LESLIE R. MILES JR. M.D.		22a. BUR. AL. CREMAT. ON. REMOVAL (Specify) Burial	
22b. DATE THEREOF 4/3/57		22c. NAME OF CEMETERY OR CREMATORIAL Laurel Hill Cemetery	
22d. LOCATION (City, town, or county) Moscow, Md.		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE George Eichhorn		24a. REC'D BY REGISTRAR DATE 4-4-57	
ADDRESS Lonaconing, Md.		24b. REGISTRAR'S SIGNATURE See Nancy K. Lee	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be retained for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

APR 11 1957

REGELVÉO

3526

CERTIFICATE OF DEATH

03530

Reg. Dist. No. 4

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be retained for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY ALLEGANY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 10 DAYS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL MEMORIAL & WARWICK AVES.		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND	
3. NAME OF DECEASED (Type or print) JOHN WILLIAM BURNS		4. DATE OF DEATH APRIL 28 1957.	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH JUNE 30, 1894
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Manager		10b. KIND OF BUSINESS OR INDUSTRY Mem. Hospital	
13. FATHER'S NAME GEORGE W. BURNS		11. BIRTHPLACE (State or foreign country) MONTANA	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unknown) No		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
16. SOCIAL SECURITY NO. 217-10-6712		17. INFORMANT MEMORIAL HOSPITAL	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 465.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c) Myocarditis & Decompensation 18 mos		INTERVAL BETWEEN ONSET AND DEATH 24 hrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June</u> , 1957, to <u>Apr. 28</u> , 1957, that I last saw the deceased alive on <u>Apr. 28</u> , 1957, and that death occurred at <u>3:48 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE DR. CLAY E. DURRETT		ADDRESS (Street, city or town, state) M.D. 236 W. 2nd Cumberland 4/28/57	
DATE SIGNED 4/28/57			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF May 1, 1957	
22c. NAME OF CEMETERY OR CREMATORIAL Davis Mem. Park		22d. LOCATION (City, town, or county) Allegany County	
23. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer, Cumberland, Maryland		24a. REC'D BY REGISTRAR DATE May 1, 1957	
		24b. REGISTRAR'S SIGNATURE John J. Hafer, Cumberland, Maryland Acting A.S.H.O.	

BUREAU V. S

JAY 3 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03531

3586

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH
a. COUNTY

Allegany

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

RFD #3 Cumberland, Md.

c. LENGTH OF STAY IN 1b

d. NAME OF HOSPITAL (If not in hospital, give street address)
OR INSTITUTION

RFD #3 Bedford Rd.

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)

a. STATE

Maryland

b. COUNTY

Allegany

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

near Cumberland, R.F.D. #3

d. STREET ADDRESS

Bedford Rd.

IS RESIDENCE
ON A FARM?
YES NO 3. NAME OF
DECEASED
(Type or print)

First

Middle

Last

4. DATE
OF
DEATHMonth
AprilDay
3Year
1957

5. SEX

Male

6. COLOR OR RACE

W.

7. MARRIED NEVER MARRIED WIDOWED DIVORCED

8. DATE OF BIRTH

June 10, 1879

9. AGE (In years
lost birthday)

77 yrs

10. IF UNDER 1 YEAR

Months

11. IF UNDER 24 HRS

Days

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work done
during most of working life, even if retired)

Pipefitter

10b. KIND OF BUSINESS OR INDUSTRY

B.R.R.

11. BIRTHPLACE (State or foreign country)

Frederick, Md.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Jacob B. Burns

14. MOTHER'S MAIDEN NAME

Mary E. Gaver

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unknown)
No.

16. SOCIAL SECURITY NO.

(If yes, give war or date of service)

17. INFORMANT

Willard Ambrose R.F.D. 3 Cumberland, Md.

Address

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

DUE TO

Conditions, if any, which
gave rise to immediate
cause (a), stating the under-
lying cause last.

(b)

DUE TO

(c)

INTERVAL BETWEEN
ONSET AND DEATH

5 years

MEDICAL CERTIFICATION

4-1-57

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

4-1-57

Chronic Bronchitis

19. WAS AUTOPSY
PERFORMED?
YES NO 20a. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF DEATH
(If either, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour a.m. 19
p.m.20d. INJURY OCCURRED
While Not while
at work at work 20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I attended the deceased from Wednesday, April 1, 1957 to April 3, 1957 that I last saw the deceased
alive on April 1, 1957, and that death occurred at 10 A.M. from the causes and on the date stated above.

ADDRESS (Street, city or town, state)

DATE SIGNED

ACTUAL
SIGNATURE

J. T. Johnson Jr M.D.

PHYSICIAN'S
(Name) (Type)

J. T. Johnson Jr M.D.

Cumberland, Md. 4-3-57

Cumberland, Md. 4-3-57

Cumberland, Md. 4-3-57

Cumberland, Md. 4-3-57

22a. BURIAL, CREMATION,
REMOVAL (Specify)

Burial 4/9/57

Burial 4/9/57

22b. DATE THEREOF

Bellcrest Cem.

Bellcrest Cem.

22c. NAME OF CEMETERY OR CREMATORI

Bellcrest Cem.

Bellcrest Cem.

22d. LOCATION (City, town, or county)

Cumberland

Cumberland

23. FUNERAL DIRECTOR'S SIGNATURE

Lamie Stein Inc. Cumb. Md.

Lamie Stein Inc. Cumb. Md.

ADDRESS

Lamie Stein Inc. Cumb. Md.

Lamie Stein Inc. Cumb. Md.

24a. REC'D BY REGISTRAR

April 5, 1957

April 5, 1957

24b. REGISTRAR'S SIGNATURE

W.F. Frank Jr. M.D.

W.F. Frank Jr. M.D.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be filed with page 3 should be filed for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED
LIBRARY

APR 8 1957

BUREAU W. F.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03532

3527

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH a. COUNTY ALLEGANY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND		b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN lb 46 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL, MEMORIAL AVE.		d. STREET ADDRESS RT. #5 Cumberland, Md.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First LARRY	Middle ALLEN	Last CAGE	4. DATE OF DEATH 8 4/5	Month Year 1957	Day	Year
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 1/29/55	9. AGE (In years last birthday) 2 yrs.	10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY none		11. BIRTHPLACE (State or foreign country) CUMBERLAND, MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME PAUL F. CAGE				14. MOTHER'S MAIDEN NAME MRS MARY F. RAVENSCROFT			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, Unknown) No		16. SOCIAL SECURITY NO. none		17. INFORMANT MEMORIAL HOSPITAL, CUMBERLAND, MD.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c) Hydrocephalus, acute INTERVAL BETWEEN ONSET AND DEATH since birth							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Pectechial hemorrhage in stomach, slight hemorrhage abdomen 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)					
20c. TIME OF INJURY Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> or work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Oct. 15, 1956, to April 5, 1957, that I last saw the deceased alive on April 5, 1957, and that death occurred at 10:15 AM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) M.D. 112 Bedford St. Cumberland, Md. Apr. 5, 1957 DATE SIGNED							
ACTUAL SIGNATURE P.A. Reiter		PHYSICIAN'S NAME (Type) P.A. REITER					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-8-57		22c. NAME OF CEMETERY OR CREMATORIAL Rest Lawn Cemetery		22d. LOCATION (City, town, or county) (State) Cash Valley, Cumberland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli, Cumberland, Md.				ADDRESS		24a. REC'D BY REGISTRAR Date April 8, 1957	24b. REGISTRAR'S SIGNATURE W.R. Frantz, M.D.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be retained for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED
BUREAU V. A.

APR 9 1957

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **72 hours** after death. After this bottom copy is signed by the physician or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 104

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

03533

CERTIFICATE OF DEATH

3574

Reg. Dist. No. 9

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN	44 LEGAN Y MARYLAND FROSTBURG 4 days	STATE CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN	MARYLAND COUNTY ALLEGANY MT. SAVAGE
HOSPITAL OR INSTITUTION OR STREET ADDRESS	STREET ADDRESS (If rural give location)		
Miners Hospital			
3. NAME OF DECEASED (Type or Print)		4. DATE OF DEATH	
Rose (First) MARIE (Middle) CARTER (Last)		April 14 (Month) (Day) (Year) 1957	
5. SEX Female	6. COLOR OR RACE WHITE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) SIN	8. DATE OF BIRTH Sept. 17 1956
10e. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		9. AGE last birthday 7 MONTHS	
10b. KIND OF BUSINESS OR INDUSTRY Frostbank		11. BIRTHPLACE (State or foreign country) Miners Hospital Frostbank USA	
13. FATHER'S NAME FRANCIS CARTER		12. CITIZEN OF WHAT COUNTRY? USA	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO. VIRGINIA Lee SMITH	
17. INFORMANT & ADDRESS FRANCIS CARTER, MT. SAVAGE Md		18. MEDICAL CERTIFICATION IMMEDIATE CAUSE (A) <i>Self exhaustion from Unnatural</i> ANTECEDENT CAUSE(S) DUE TO (B) <i>"Flu" C Diarrhea & vomiting</i> DISEASES OR CONDITIONS, IF ANY, (C) <i>4 day</i> GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County)		(State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. at work		21e. INJURY OCCURRED While Not while at work	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>2 p.m.</i> 1957, to <i>2 p.m.</i> 1957, that I last saw the deceased alive on <i>2 p.m.</i> 1957, and that death occurred at <i>3:29 p.m.</i> from the causes and on the date stated above. SIGNATURE <i>John B. Davis, M.D.</i> ADDRESS (Street, city, town, state) <i>Frostburg, Md.</i> DATE SIGNED <i>4/15/57</i>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF APRIL 17, 1957	
24. REC'D BY REGISTRAR DATE 4-16-57		NAME OF CEMETERY OR CREMATORIAL ST. PATRICKS Cemetery MT. SAVAGE Md	
REGISTRAR'S SIGNATURE M. Harvey H. Rose		LOCATION (City, town, or county) (State)	
25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Harvey H. Leigh, Hyndman, Jr.			

RECEIVED
BUREAU A. S.

1957

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 03534

1 Within corporate limits
 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
 page 3 should be retained for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

DR. R.J. WILLIAMS 3528		CERTIFICATE OF DEATH	
1. PLACE OF DEATH a. COUNTY ALLEGANY		2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 3 DAYS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND	
3. NAME OF DECEASED (Type or print) ALTA		First M.	Middle CESSNA
4. DATE OF DEATH APRIL 4, 1957		5. SEX FEMALE	6. COLOR OR RACE WHITE
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH APRIL 21, 1884	
9. AGE (in years lost birthday) 72 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic in		10b. KIND OF BUSINESS OR INDUSTRY Private homes	
11. BIRTHPLACE (State or foreign country) WEST VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME WILLIAM CESSNA		14. MOTHER'S MAIDEN NAME MARY MERCHANT	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 214-05-9350	
17. INFORMANT MEMORIAL HOSPITAL - CUMBERLAND, MD.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 410X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 4 days not known	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>6/8/54</u> , 19, to <u>4/4/57</u> , 19, that I last saw the deceased alive on <u>4/3/57</u> , 19, and that death occurred at <u>2:45</u> A.M. from the causes and on the date stated above. ACTUAL SIGNATURE <u>R.J. Williams</u> M.D. ADDRESS (Street, city or town, state) PHYSICIAN'S NAME (Type) DR. R.J. WILLIAMS DATE SIGNED <u>4/4/57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF April 6, 1957	
22c. NAME OF CEMETERY OR CREMATORIAL Rose Hill Cemetery		22d. LOCATION (City, town, or county) Cumberland, Maryland (State)	
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpell, Cumberland, Maryland.		24a. REC'D BY REGISTRAR April 5, 1957	
		24b. REGISTRAR'S SIGNATURE W.R. Frantz, M.D.	

RECEIVED
APR 3 1957
MURRAY V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03535

Within corporate limits

3529

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH a. COUNTY Allegany		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Allegany		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN lb 23 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Sacred Heart Hospital		d. STREET ADDRESS Bell Street		e. STREET ADDRESS 222 Bell Street		e. IS RESIDENCE ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Alice		First	Middle Rosetta	Last Clise	4. DATE OF DEATH Month April Day 4 Year 19 57	Month April	Day 4	Year 19 57
5. SEX Female	6. COLOR OR RACE White	7. MARRIED NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-11-06	9. AGE (In years last birthday) 50 yrs	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	12. IF UNDER 24 HRS. Hours 0	13. MIN 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laundry Worker		10b. KIND OF BUSINESS OR INDUSTRY Hospital		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.		
13. FATHER'S NAME Albert Capel			14. MOTHER'S MAIDEN NAME Beatrice Wright			Address		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 214-28-6485		17. INFORMANT Patient's Chart				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Respiratory tract disease & anemia</i> DUE TO <i>Fulmination</i> INTERVAL BETWEEN ONSET AND DEATH <i>2 months</i> (b) <i>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.</i> DUE TO <i>Respiratory tract disease & anemia</i> (c) <i>Fulmination</i>								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) YES <input type="checkbox"/> NO <input type="checkbox"/>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	Day	20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) 43 Greene Street	(County) Baltimore, Md.	(State) Md.	
21. I certify that I attended the deceased from January , 19 57 , to March 4 , 19 57 , that I last saw the deceased alive on March 4 , 19 57 , and that death occurred at 43 Greene Street, Baltimore, Md. from the causes and on the date stated above. ACTUAL SIGNATURE B. M. Schindler M. D. ADDRESS (Street, city or town, state) 43 Greene Street, Baltimore, Md. DATE SIGNED 4/1/57								
22a. PHYSICIAN'S NAME (Type) B. M. Schindler M. D.		22b. DATE THEREOF April 7, 1957		22c. NAME OF CEMETERY OR CREMATORIUM Frostburg Memorial Cemetery		22d. LOCATION (City, town, or county) Frostburg, Md. (State) Md.		
23. FUNERAL DIRECTOR'S SIGNATURE Charles L. George, Cumberland, Md.		ADDRESS		24a. REC'D BY REGISTRAR April 5, 1957		24b. REGISTRAR'S SIGNATURE W. Frank M. D.		

BUREAU V. S.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03536

3539

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH a. COUNTY ALLEGANY		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN lb 9 DAYS		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE WEST VIRGINIA		b. COUNTY HAMPSHIRE	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL MEMORIAL & WARWICK AVES.				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) GREENSPRING		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First MILDRED	Middle A.	Last COMER	4. DATE OF DEATH	Month APRIL	Day 2	Year 1957		
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH SEPTEMBER 28, 1906	9. AGE (In years last birthday) 55 yrs	IF UNDER 1 YEAR Months	IF UNDER 24 HRS Days	Hours	Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) WEST VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME ALBERT ARNOLD				14. MOTHER'S MAIDEN NAME SARA LLOYD					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT MEMORIAL HOSPITAL - CUMBERLAND, MD.		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 5-2 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO (c)				Cerebral Thrombosis Generalized Arteriosclerosis				INTERVAL BETWEEN ONSET AND DEATH unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Operative on August 56 ft fibroid (regressing)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)							
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County)	(State)				
21. I certify that I attended the deceased from 3.24.1957 to 4.30.1957 that I last saw the deceased alive on 4.2.1957, and that death occurred at 9:50P.M. from the causes and on the date stated above.				ADDRESS (Street, city or town, state) Cumberland, Md 4-3-57				DATE SIGNED	
ACTUAL SIGNATURE W. F. Williams		M.D.							
PHYSICIAN'S NAME (Type) DR. W. F. WILLIAMS.									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF April 5, 1957		22c. NAME OF CEMETERY OR CREMATORIAL Forest Glen Cemetery		22d. LOCATION (City, town, or county) Greenspring, West Virginia		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE Lester Shaffer				ADDRESS Greenspring 4-1-1		24a. REC'D BY REGISTRAR Date April 5, 1957		24b. REGISTRAR'S SIGNATURE W. K. Hank, M.D.	

REAU Y. A.

APR 8 1962

REGISTRY FILE

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03537

CERTIFICATE OF DEATH

Reg. Dist. No. 4

56-45164

3531

1. PLACE OF DEATH
a. COUNTY

Allegany

MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)

a. STATE

Maryland

b. COUNTY

Allegany

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Cumberland

c. LENGTH OF STAY IN lb

12 dys.

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Rt. # 3 Cumberland, rural

d. NAME OF HOSPITAL (If not in hospital, give street address)
OR INSTITUTION

Memorial Hosp.

d. STREET ADDRESS

Valley Rd.

e. IS RESIDENCE
ON A FARM?YES NO 3. NAME OF
DECEASED
(Type or print)First
EMMAMiddle
ARRETTALast
COOK4. DATE
OF
DEATHMonth
AprilDay
20,Year
1957

5. SEX

Female

6. COLOR OR RACE

White

7. MARRIED NEVER MARRIED WIDOWED DIVORCED

8. DATE OF BIRTH

Mar. 9, 1893

9. AGE (In years
last birthday)

64

yrs.

10. USUAL OCCUPATION (Give kind of work done
during most of working life, even if retired)

Housewife

10b. KIND OF BUSINESS OR INDUSTRY

Own home

11. BIRTHPLACE (State or foreign country)

Romney, W. Va.

12. CITIZEN OF WHAT COUNTRY?

U. S.

13. FATHER'S NAME

John Bowman

14. MOTHER'S MAIDEN NAME

Arretta (Unknown)

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unknown)
If yes, give war or date of service)

No,

16. SOCIAL SECURITY NO.

None

17. INFORMANT

Mr. William C. Cook Rt. # 3 Cumberland, Md.

Address

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

Uremia

INTERVAL BETWEEN
ONSET AND DEATH

DUE TO

Conditions, if any, which
gave rise to immediate
cause (a), stating the under-
lying cause last.

(b)

Chronic Nephritis

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY
PERFORMED?YES NO 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour a. m. 19
p. m.20d. INJURY OCCURRED
While at work Not while at work 20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)20f. (City or town)
(County)

(State)

21. I certify that I attended the deceased from 1946, 19, to 2052, 1952, that I last saw the deceased
alive on 20 Apr 1, 1952, and that death occurred at 7:00 P.M. from the causes and on the date stated above.

ADDRESS (Street, city or town, state)

DATE SIGNED

ACTUAL
SIGNATURE

Fuller B. Whitworth, M.D.

123 Bedford St.,

PHYSICIAN'S
NAME (Type)

Cumberland, Md.

22a. BURIAL, CREMATION
REMOVAL (Specify)

Burial

22b. DATE THEREOF

4/23/57

22c. NAME OF CEMETERY OR CREMATORIUM

Mt. Pleasant Cemetery

22d. LOCATION (City, town, or county)

Near Cumberland, Md.

(State)

23. FUNERAL DIRECTOR'S SIGNATURE

Charles L. George Cumberland, Md.

ADDRESS

24a. REC'D. BY REGISTRAR

Apr 23, 1957

24b. REGISTRAR'S SIGNATURE

Charles L. George, M.D.

REGEL V. FEDERAL BUREAU OF INVESTIGATION

APR 21 1967

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **43538**

3587

1. PLACE OF DEATH a. COUNTY Allegany		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Md. b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lonaconing		c. LENGTH OF STAY IN 1b 2 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lonaconing	
f. STREET ADDRESS /		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First James	Middle Crawford	4. DATE OF DEATH April 23
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 1883
9. AGE (In years last b'rhday) 73 yrs.		10. IF UNDER 1 YEAR Months 0 Days 0	11. IF UNDER 24 HRS. Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Coal Mine	
11. BIRTHPLACE (State or foreign country) Scotland		12. CITIZEN OF WHAT COUNTRY? Scotland ✓	
13. FATHER'S NAME James Crawford		14. MOTHER'S MAIDEN NAME Christine McConn	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) None		16. SOCIAL SECURITY NO. none	
17. INFORMANT (sister) Mrs. George Graham, Lonaconing, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Coronary sclerosis ? (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Name, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>			
ACTUAL SIGNATURE <i>H. V. Deming M.D.</i>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED April 23-1957
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/26/57	22c. NAME OF CEMETERY OR CREMATORIUM E.U.B. Cemetery
22d. LOCATION (City, town, or county) Jenner Cross Roads, Pa.		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE George Eichhorn		24a. REC'D BY REGISTRAR Jeanette M. Goad	24b. REGISTRAR'S SIGNATURE
ADDRESS Lonaconing, Md.		DATE 4/26/57	

PUT IN MEDICAL EXAMINER'S OFFICE

This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial/transit permit. File pages 1 and 2 with the registrar prior to burial or removal.

MEAU V. S.

AL 1 1957

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03539

3532

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived) b. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 105 Independence Street		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland	
3. NAME OF DECEASED First BESSIE Middle MAY Last CUNNINGHAM		4. DATE OF DEATH April 10, 1957 Month Day Year 19	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 17, 1877
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Flintstone, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME James Ash		14. MOTHER'S MAIDEN NAME Amanda Lashley	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Eugene Cunningham		107 Independence Street Address Cumberland, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Embolus		immediate	
DUE TO Auricular fibrillation, Coronary Arteriosclerosis, (b) Coronary Insufficiency		14 years	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
Chronic Myocardial Decompensation			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from January 1943, to April 10, 1957, that I last saw the deceased alive on April 6, 1957, and that death occurred at 7 A. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE		ADDRESS (Street, city or town, state) DATE SIGNED	
PHYSICIAN'S NAME (Type) Samuel M. Jacobson, M.D., F.A.C.P.		50 Pershing St., Cumberland, Md. 4-11-57.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/13/57	
22c. NAME OF CEMETERY OR CREMATORIUM Hillcrest Burial Park		22d. LOCATION (City, town, or county) (State) Cumberland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer, Cumberland, Maryland		24a. REC'D BY REGISTRAR DATE April 13, 1957	
		24b. REGISTRAR'S SIGNATURE W. Frank, M.D.	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED
BUREAU V. S.

APR 17 1977

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03540

3533

CERTIFICATE OF DEATH

Reg. Dist. No. 4

TO HOSPITAL ■ ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be retained for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY ALLEGANY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE MARYLAND		b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 16 4 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) XO CUMBERLAND LA VALE			
d. NAME OF HOSPITAL OR INSTITUTION (If not a hospital, give street address) MEMORIAL HOSPITAL, MEMORIAL & WARWICK AVES.				d. STREET ADDRESS RT. #6, Box 182		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) ROGER		First P.	Middle CURRY	4. DATE OF DEATH APRIL 28 1957	Month APRIL	Year 28	Year 1957
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH DECEMBER 12, 1935		9. AGE (In years last birthday) 21	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Days 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		10b. KIND OF BUSINESS OR INDUSTRY none		11. BIRTHPLACE (State or foreign country) CUMBERLAND, MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME FOY ADAMS CURRY		14. MOTHER'S MAIDEN NAME KATE GRIMM					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO 577-50-1687		17. INFORMANT Foy A. Curry	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>meningitis, acute, meningoencephalitis</i> 7 days. DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b). DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause (c). INTERVAL BETWEEN ONSET AND DEATH		
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Cirrhosis Liver, Auralia 2 years</i>		21. I certify that I attended the deceased from 1 May 1956 to 27 Apr. 1957 that I last saw the deceased alive on 27 Apr. 1957 , and that death occurred at 4:30 P.M. from the causes and on the date stated above. ACTUAL SIGNATURE <i>W. Alfred Van Ormer M.D.</i> ADDRESS (Street, city or town, state) <i>1225 Centre St. 27091.57</i> DATE SIGNED PHYSICIAN'S NAME (Type) <i>W. ALFRED VAN ORMER</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation 4/30/57		22b. DATE THEREOF 4/30/57		22c. NAME OF CEMETERY OR CREMATORIUM Cedar Hill Crematorium		22d. LOCATION (City, town, or county) Washington, D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer, Cumberland, Maryland		ADDRESS John J. Hafer, Cumberland, Maryland		24a. REC'D. BY REGISTRAR DATE 29 Apr. 1957		24b. REGISTRAR'S SIGNATURE <i>W. R. Frantz, M.D.</i>	

RECEIVED
BUREAU A. S.

PR 30 1957

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03541

Within corporate limits

CERTIFICATE OF DEATH

Reg. Dist. No. 4

3531

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Allegany		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 3/16/55		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Allegany County Infirmary		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		
3. NAME OF DECEASED (Type or print) Charles Ralph Darrow		d. STREET ADDRESS 302 N. Waverly Terrace		
3. NAME OF DECEASED (Type or print) Charles Ralph Darrow		4. DATE OF DEATH April	Month Day Year 8, 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 1/27/1894	
9. AGE (In years lost birthday) 63		10. IF UNDER 1 YEAR Months yes	11. IF UNDER 24 HRS Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired - Celanese Worker		10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) Cumberland, Maryland		
13. FATHER'S NAME Charles S. Darrow		14. MOTHER'S MAIDEN NAME Bessie Lowdermilk		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or Ind) no		16. SOCIAL SECURITY NO. 18-05-6309	17. INFORMANT P.O. Box 599 Address Cumberland, Md. Allegany County Infirmary Records	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 48 hrs 2 yrs 2 yrs		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Hour a.m. p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 49 Greene St.	(County)	(State)
21. I certify that I attended the deceased from 3/16/55, 19, to 4/8/57, 19, that I last saw the deceased alive on 4/8/57, 19, and that death occurred at 9:45 PM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 49 Greene St. DATE SIGNED 4/9/57				
ACTUAL SIGNATURE Dr. James E. McLean, M.D. PHYSICIAN'S NAME (Type)				
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 4/11/57	22c. NAME OF CEMETERY OR CREMATORIAL Frostburg Memorial Park	22d. LOCATION (City, town, or county) Frostburg, Maryland	(State)
23. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer, Cumberland, Maryland		24a. REC'D BY REGISTRAR April 11, 1957	24b. REGISTRAR'S SIGNATURE W.H. Hafer, M.D.	

RECEIVED
1957
75

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03542

3535

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ALLEGANY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND		b. COUNTY ALLEGANY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 4 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 32 CUMBERLAND				
d. NAME OF HOSPITAL (If not a hospital, give name and address) OR INSTITUTION MEMORIAL HOSPITAL MEMORIAL & WARWICK AVES.,				d. STREET ADDRESS 608 VIRGINIA AVE.,		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)		First CECIL	Middle V.	Last DAVIS	4. DATE OF DEATH APRIL 11 1957	Month APRIL	Day 11	Year 1957
S. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH DEC. 19, 1910		9. AGE (In years last birthday) 46 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	12. IF UNDER 24 HRS. Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Dye House worker		10b. KIND OF BUSINESS OR INDUSTRY Celenese Corp		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME WILLIAM L. DAVIS				14. MOTHER'S MAIDEN NAME ELLA VALENTINE				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 212-18-1188		17. INFORMANT Frank Davis		Address Cumberland Md.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac failure - ventricular fibrillation</i> INTERVAL BETWEEN DUE TO <i>7 hrs.</i> Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) <i>Rheumatic valvulitis and General arteriosclerosis</i> (c) <i>Trnk.</i>								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Aspiration Apr. 11/10, General malnutrition and massive edema</i> 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>								
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)				
21. I certify that I attended the deceased from <u>7 April</u> , 1957, to <u>11 April</u> , 1957, that I last saw the deceased alive on <u>11 April</u> , 1957, and that death occurred at <u>8:55 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <i>Carlton Brinsfield</i> M.D. <u>232 Baltimore Av</u> <u>April 11</u>								
22a. BURIAL, CREMATION, REMOVAL (SPECIES) Burial		22b. DATE THEREOF April 14/57		22c. NAME OF CEMETERY OR CREMATORIUM Davis Memorial Burial Park		22d. LOCATION (City, town, or county) Cumberland Md. (State)		
23. FUNERAL DIRECTOR'S SIGNATURE William H. Kight		ADDRESS Cumberland, Md.		24. REC'D. BY REGISTRAR <u>April 12, 1957</u>		25. REGISTRAR'S SIGNATURE <u>W.H. Kight, M.D.</u>		

RECEIVED
BUREAU V. S.

APR 5 1957

Outside of
City Limits
III

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 03543
3588 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Md. b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 40 yrs	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Box 476 Valley Road		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland (rural)	
3. NAME OF DECEASED (Type or print) John Calvin		First Middle Last Dick	4. DATE OF DEATH April 19 1957
5. SEX male	6. COLOR OR RACE white	7. MARRIED WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 24-1895
9. AGE (In years last birthday) 61 yrs.		10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Guard at the Allegany Ballestic Lab.		10b. KIND OF BUSINESS OR INDUSTRY Frostburg, Md.	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Christian Dick		14. MOTHER'S MAIDEN NAME Elizabeth Hedrick	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. W.W.1 214-07-0304 (wife) Ruth Hausman Dick, Cumberland, Md.	
17. INFORMANT Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1		Coronary occlusion	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)		Coronary sclerosis	
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>		DATE SIGNED	
ACTUAL SIGNATURE	H. V. Deming M.D.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> April 20-1957
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF April 22, 1957	22c. NAME OF CEMETERY OR CREMATORIUM Greenmount Cemetery	22d. LOCATION (City, town, or county) (State) Cumberland, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer, Cumberland, Maryland.		24a. REC'D BY REGISTRAR April 22, 1957	
ADDRESS Hafer		24b. REGISTRAR'S SIGNATURE A. L. Frank M.D.	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please initial the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 is to be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to removal.

VS. A15ME(S)
5M 9/55

BUREAU

APR 24 1957

REGELVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03544

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

3536

Reg. Dist. No. 4

1. PLACE OF DEATH a. COUNTY Allegany		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Md. b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b Cumberland	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 122 S. Lee St.		d. STREET ADDRESS 122 S. Lee St.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Virginia	First First	Middle Bell	Last Early
4. DATE OF DEATH April 21 1957	Month Month	Day Day	Year Year
5. SEX female	6. COLOR OR RACE colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 31-1900
		9. AGE (In years last birthday) 57 yrs.	10. IF UNDER 1 YEAR Months 0 Days 0
			11. IF UNDER 24 HRS. Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Frostburg, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James Waites		14. MOTHER'S MAIDEN NAME Mary Nelson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. none	
17. INFORMANT (daughter) Mary Brown, Cumberland, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial failure			
DUE TO 442X			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cardio-vascular-renal disease			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, Farm, factory, street, office bldg., etc.)
20f. (City or town) Cumberland		(County) Maryland	
(State) Maryland			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>			
ACTUAL SIGNATURE <i>H.V. Deming M.D.</i>		DATE SIGNED April 22-1957	
EXAMINER'S NAME (Type) H.V. Deming M.D.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input type="checkbox"/> April 22-1957	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF April 24, 1957	
22c. NAME OF CEMETERY OR CREMATORIAL Woodlawn Burial Park		22d. LOCATION (City, town, or county) Cumberland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer, Cumberland, Maryland.		24a. REC'D BY REGISTRAR John J. Hafer, Cumberland, Maryland	
		24b. REGISTRAR'S SIGNATURE John J. Hafer, Cumberland, Maryland	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "Pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-troussal permit. File Pages 1 and 2 with the registrar prior to burial, cremation, or removal.

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LIBRARY

APR 24 1957

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03545

3575

CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH a. COUNTY Allegany		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg		b. COUNTY Allegany	
c. LENGTH OF STAY IN 1b life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Route 3		d. STREET ADDRESS Route 3	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First J.	Middle WESLEY	Last ENGLE
4. DATE OF DEATH	Month APRIL	Day 27	Year 1957
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 3-8-1889
9. AGE (In years from birthday) 68	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Days 0	12. IF UNDER 24 HRS Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) farmer	10b. KIND OF BUSINESS OR INDUSTRY own farm	11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Vincent Engle	14. MOTHER'S MAIDEN NAME Hattie Porter	Address	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. 215-36-9804A	17. INFORMANT Mrs. Wesley Engle, Rt. 3, Frostburg	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio - vascular renal			
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) disease			
DUE TO (c)			
INTERVAL BETWEEN ONSET AND DEATH 3-4 yrs.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from August, 1957 , to 4-27, 1957 , that I last saw the deceased alive on 4-26, 1957 , and that death occurred at 11 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) W. Main St., Frostburg, Md. DATE SIGNED H. C. Diehl, M. D.			
ACTUAL SIGNATURE			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 22b. DATE THEREOF 4-30-1957 22c. NAME OF CEMETERY OR CREMATORIUM Porter Cemetery 22d. LOCATION (City, town, or county) Eckhart, Md. (State)			
23. FUNERAL DIRECTOR'S SIGNATURE J. R. Durst, Frostburg, Md.		ADDRESS	24a. REC'D BY REGISTRAR 4-30-57 24b. REGISTRAR'S SIGNATURE W. Dailey Hobbs

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be attached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. 2
REGULATIVE

JAY 2 1957

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03546

Within corporate limits

3537

CERTIFICATE OF DEATH

Reg. Dist. No. 4

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be reigned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be retained for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission)		a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Cumberland		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Cumberland	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		Allegany County Infirmary		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First Martin	Middle R.	Last Evans	4. DATE OF DEATH April	Month 29,	Day Year 1957
5. SEX		6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (in years last birthday)	10. IF UNDER 1 YEAR Months 76 yrs.	11. IF UNDER 24 HRS Days Hours Min.
Male		White		1/23/1881	76 yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Retired-Farmer		Farming		Petersburg, W. Va.		U. S. A.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME					
John Evans		Jane Keplinger					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) no		16. SOCIAL SECURITY NO. 220-10-2259		17. INFORMANT P.O. Box 599		Address Cumberland, Md.	
						Allegany County Infirmary Records	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]		Hemorrhagic Cerebral Arteriosclerosis				INTERVAL BETWEEN ONSET AND DEATH 36 hrs.	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Chronic Hypertension				?	
420.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last		Cerebral Arteriosclerosis				?	
DUE TO (b)							
DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		Hypertension - a sequel to cerebral arteriosclerosis				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> TO CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED White Not white at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)	(County) (State)
21. I certify that I attended the deceased from 6/11/57, 19, to 4/29/57, 19, that I last saw the deceased alive on 4/29/57, 19, and that death occurred at 9:45 P.M. from the causes and on the date stated above.						ADDRESS (Street, city or town, state)	
ACTUAL SIGNATURE		Dr. James E. McLean, M.D.				DATE SIGNED 4/30/57	
PHYSICIAN'S NAME (Type)		Cumberland, Md.					
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORIAL		22d. LOOKING TOWARD (City or town, county, state)	
Burial		May 2, 1957		Stallings Cemetery		Near Allegany County, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
John J. Hafer, Cumberland, Maryland				May 1, 1957		W. Rose Cameron, M.D.	

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MAY 3 1957

may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

103547

3576

CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH a. COUNTY Allegany		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) b. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg		c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) MOUNT SAVAGE	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Miners Hospital		d. STREET ADDRESS Box 534	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) KATHY ANN G. FAIDLEY	First KATHY	Middle ANN	Last FAIDLEY
4. DATE OF DEATH April 24, 1957	Month April	Day 24	Year 1957
5. SEX Female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 24, 1957
9. AGE (In years last birthday) yrs. 17	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Days 0	12. Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) infant	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME Robert Faidley		14. MOTHER'S MAIDEN NAME Madlyn Snyder	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no or unknown) Yes	16. SOCIAL SECURITY NO none	17. INFORMANT Robt. Faidley, Mt. Savage, Md.	Address
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) 776X		INTERVAL BETWEEN ONSET AND DEATH 17 hrs.	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) M.D.
20f. (City or town) Frostburg, Md.		(County) Jefferson (State) Md.	
21. I certify that I attended the deceased from 4-24 , 1957, to 4-24 , 1957, that I last saw the deceased alive on 4-24 , 1957, and that death occurred at 11:45 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE H.C. Diehl.		ADDRESS (Street, city or town, state) Frostburg, Md. DATE SIGNED 4/25/57	
PHYSICIAN'S NAME (Type) H.C. Diehl, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-25-57	22c. NAME OF CEMETERY OR CREMATORIAL Methodist Cemetery
22d. LOCATION (City, town, or county) Mt. Savage, Md.		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE J. R. Durst,		24a. ADDRESS Frostburg, Md.	24b. REC'D BY REGISTRAR DATE 4-25-57
		24b. REGISTRAR'S SIGNATURE John D. F. Ross	

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MAY 3 1957

BUREAU V. S

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03548

DR. HIMMELWRIGHT

3538

CERTIFICATE OF DEATH

Reg. Dist. No. 4

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
 page 3 should be detached for use as the burial-travel permit. Then please remove carbon paper. Pages 1 and 2 should be filed with
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY ALLEGANY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE MARYLAND		b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 8 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		d. STREET ADDRESS 202 LAING AVE., CUMBERLAND, MD.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) NINA		First MIDDLE MAY		4. DATE OF DEATH Lost FELTON		Month Day Year APRIL 7, 1957	
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 10-1-1905		9. AGE (In years lost birthday) yrs 51	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY Our Home		11. BIRTHPLACE (State or foreign country) FRIENDSVILLE, MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME SAMUEL PRICE FRIEND		14. MOTHER'S MAIDEN NAME MARY JANE ENGLE					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give rank or grade and date of service) 76		16. SOCIAL SECURITY NO.		17. INFORMANT MEMORIAL HOSPITAL		Address CUMBERLAND, MARYLAND	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Hypertension—Cardio-vasular Disease						INTERVAL BETWEEN ONSET AND DEATH 18 hrs.	
		(b) DUE TO Hypertension—Cardio-vasular Disease				Years	
		(c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) Dehydration due to excessive emesis due to Cholecystitis		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. 19 p.m.		20d. INJURY OCCURRED White Not white at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from July 19, 1954, to April 7, 1957, that I last saw the deceased alive on April 7, 1957, and that death occurred at 2:10 PM, from the causes and on the date stated above. ACTUAL SIGNATURE G. Overton Himmelwright, M.D.				ADDRESS (Street, city or town, state) 443X			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Apr. 10, 1957		22c. NAME OF CEMETERY OR CREMATORIAL Davis Memorial Park		22d. LOCATION (City, town, or county) Cumberland (State) Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Sons Stein, Inc.		ADDRESS Cumberland, Md.		24a. REC'D BY REGISTRAR Apr. 10, 1957		24b. REGISTRAR'S SIGNATURE W. G. Grant, M.D.	

BUREAU Y.

APR 11 1957

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03549

3577

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg		c. LENGTH OF STAY IN 1b life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 39 Bowery St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) RICHARD	First RICHARD	Middle C.	4. DATE OF DEATH April 28, 1957
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-3-1900
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) self employed		10b. KIND OF BUSINESS OR INDUSTRY Grocery store	11. BIRTHPLACE (State or foreign country) Maryland
13. FATHER'S NAME James Fram		14. MOTHER'S MAIDEN NAME Joanna Preston	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (For no. or unknown) No		16. SOCIAL SECURITY NO. 214-07-1568	17. INFORMANT Mrs. Richard Fram, Frostburg, Md.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Infarction INTERVAL BETWEEN ONSET AND DEATH 15 min 4/28 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Hour o. m. p. m.	Month Day Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 4/28/57 , 19 57 , to 4/28 , 19 57 , that I last saw the deceased alive on 4/28 , 19 57 , and that death occurred at 9:15 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) E. Main St., Frostburg, Md. DATE SIGNED John C. Devers			
ACTUAL SIGNATURE		PHYSICIAN'S NAME (Type) John C. Devers, M. D.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 5-1-1957	22c. NAME OF CEMETERY OR CREMATORIUM Zion Evan. Cemetery	22d. LOCATION (City, town, or county) (State) Frostburg, Md.
23. FUNERAL DIRECTOR'S SIGNATURE J. R. Durst,		ADDRESS Frostburg, Md.	
24a. REC'D BY REGISTRAR DATE 4-30-57		24b. REGISTRAR'S SIGNATURE Lucy H. Rose	

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BUREAU V. S.

MAY 2 1957

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 48 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completed in by the funeral director, the third copy of this death certificate should be retained for use as a burial permit.

VS 1951-155 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

03550

3539 CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY CITY (If out'side corporate limits, write RURAL OR and give nearest town) TOWN	ALLEGANY CUMBERLAND SACRED HEART HOSPITAL	MARYLAND LENGTH OF STAY (In this place) 17 days	STATE W.V.A CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN RIDGELEY STREET ADDRESS (If rural give location)
3. NAME OF DECEASED (Type or Print)		4. DATE (Month) (Day) (Year)	
(First) CHARLOTTE		FRYER April 28 1957	
(Middle)		(Last)	
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, X WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH Oct. 6, 1893
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	9. AGE last birthday 23 yrs.
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME S. Fuller Barnard		14. MOTHER'S MAIDEN NAME Emigret Finscott	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) No.		16. SOCIAL SECURITY NO. 123-45-6789	
17. INFORMANT & ADDRESS Chart		18. MEDICAL CERTIFICATION	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) THROMBOSIS OF ANEURYSM OF AORTA		INTERVAL BETWEEN ONSET AND DEATH UNCERTAIN	
ANTECEDENT CAUSE(S) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) ANEURYSM OF ASCENDING PART AND AORTA DUE TO OF AORTA		2 years from	
(C) MICROSCOPIC RHEUMATOID ARTHRITIS & ANGIOSCLEROSIS OF AORTA		1955	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from....., 1955, to....., 1957, that I last saw the deceased alive on....., 1957, and that death occurred at....., 708 P.M., from the causes and on the date stated above. SIGNATURE X. C. W. Barnard			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF May 21, 1957	
NAME OF CEMETERY OR CREMATORIAL St. Joseph's Cemetery		LOCATION (City, town, or county) Towson, Baltimore, Maryland	
24. REC'D BY REGISTRAR DATE April 30, 1957		REGISTRAR'S SIGNATURE Walter P. Frantz, M.D.	
25. FUNERAL DIRECTOR'S SIGNATURE DATE		ADDRESS	

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BUREAU V. S.

MAY 2 1947

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03551

3540

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH a. COUNTY ALLEGANY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE W.VA.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		b. COUNTY MINERAL	
c. LENGTH OF STAY IN 1b 13 HRS.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RIDGELEY	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL MEMORIAL & WARWICK AVES.,		d. STREET ADDRESS 28 Carpenter Ave.	
3. NAME OF DECEASED (Type or print) TOBIAS		First Stickley	Middle GANOE
4. DATE OF DEATH APRIL 3 1957	Month Day Year		
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JUNE 12, 1891
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Watchman		10b. KIND OF BUSINESS OR INDUSTRY Railroad	11. BIRTHPLACE (State or foreign country) W.VA. (Hampshire Co.)
13. FATHER'S NAME JAMES GANOE		14. MOTHER'S MAIDEN NAME HARRIETT BOWMAN	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.	17. INFORMANT Mrs. Willard Zirk Ridgeley, W. Va.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under lying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 4 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes mellitus		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m.	Month 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> of work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>12-5-54</u> , 19 <u>19</u> , to <u>4-3-57</u> , 19 <u>19</u> , that I last saw the deceased alive on <u>4-3-57</u> , 19 <u>19</u> , and that death occurred at <u>9:15</u> AM, from the causes and on the date stated above. ACTUAL SIGNATURE <i>Ralph W. Ballin</i>			
PHYSICIAN'S NAME (Type) Ralph W. Ballin, M.D.		ADDRESS 62 Greene St Cumberland, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 4-5-1957	22c. NAME OF CEMETERY OR CREMATORIY Green Ridge Cem.	22d. LOCATION (City, town, or county) (State) Green Ridge, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Charles L. George		ADDRESS Cumberland, Md.	
24a. REC'D BY REGISTRAR April 5, 1957		24b. REGISTRAR'S SIGNATURE W.R. Frank, M.D.	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
may be retained by the hospital or attending physician

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
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APR 8 1957

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03552

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH a. COUNTY Allegany		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) STATE Maryland		b. COUNTY Allegany		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN lb 12 hrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oldtown		d. STREET ADDRESS ' Greenspring Rd.		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Sacred Heart Hospital						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Carrie		First Viola	Middle Ginevan	Last 	4. DATE OF DEATH April 2 1957	Month April	Day 2	Year 1957
S. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 11/19/1879	9. AGE (In years last birthday) 77	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	Hours 0	Min 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S.		
13. FATHER'S NAME Thomas Runkles		14. MOTHER'S MAIDEN NAME Caroline Rucci		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or No, or unknown) No		16. SOCIAL SECURITY NO. None		
17. INFORMANT Pt's chart		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion.		19. INTERVAL BETWEEN ONSET AND DEATH				
420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO (c)								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Cumberland, Md.		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from 4-1-57 , to 4-2-57 , that I last saw the deceased alive on 7-1-57 , and that death occurred at 5:45 A.M. from the causes and on the date stated above. ACTUAL SIGNATURE C. G. Zimmerman		ADDRESS (Street, city or town, state) Cumberland, Md.						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF April 4, 1957		22c. NAME OF CEMETERY OR CREMATORIUM Oldtown Cemetery		22d. LOCATION (City, town, or county) Oldtown, Md.		
23. FUNERAL DIRECTOR'S SIGNATURE H. Wayne George		ADDRESS Cumberland, Md.		24a. REC'D BY REGISTRAR April 5, 1957		24b. REGISTRAR'S SIGNATURE H. Frank M.D.		

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APR 8 1957
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Within corporate limits

Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 4 and 2 with the registrar prior to burial, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03553

Reg. Dist. No. 4

1. PLACE OF DEATH a. COUNTY Allegany		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Md.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		b. COUNTY Allegany	
c. LENGTH OF STAY IN 1b 24 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 232 Kraft Place		d. STREET ADDRESS 232 Kraft Place	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Oscar		First Oscar	Middle
4. DATE OF DEATH April 7		Month April	Day 7
5. SEX male		6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH July 16-1905		9. AGE (in years from birthday) 51	10. IF UNDER 1 YEAR Months 0
11. BIRTHPLACE (State or foreign country) Lonaconing, Md.		12. IF UNDER 24 HRS. Days 0	13. IF UNDER 24 HRS. Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Storeroom clerk		10b. KIND OF BUSINESS OR INDUSTRY B&O R.R.	
10c. CITIZEN OF WHAT COUNTRY? U.S.A.		14. MOTHER'S MAIDEN NAME Alfretta Dodge	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 705-05-4430	
17. INFORMANT (wife) Edith Glover		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of throat with DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. pharyngeal hemorrhage also had DUE TO (b) sudden DUE TO (c) malnutrition. INTERVAL BETWEEN ONSET AND DEATH 6 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>		DATE SIGNED	
ACTUAL SIGNATURE <i>H. V. Deming M.D.</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) H. V. Deming M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-11-57	
22c. NAME OF CEMETERY OR CREMATORIAL Rose Hill Cemetery		22d. LOCATION (City, town, or county) Cumberland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli, Cumberland, Md.		24a. REC'D BY REGISTRAR April 9, 1957	
ADDRESS 		24b. REGISTRAR'S SIGNATURE W. F. Tracy, M.D.	

DUREAU Y. A.

APR 11 1957

RECEIVED

3543

CERTIFICATE OF DEATH

Reg. Dist. No. 4

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be relied on by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit Permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY ALLEGANY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND		b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 15 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND			
d. NAME OF HOSPITAL (If not hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL MEMORIAL & WARWICK AVES.				d. STREET ADDRESS 321 NORTH CENTRE ST.,		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) LAURA		First MIDDLE CATHERINE		Last GOEBEL		4. DATE OF DEATH APRIL 25	Month Day Year 1957
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7/10/77	
9. AGE (In years last birthday) 79 yrs		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS.		12. CITIZEN OF WHAT COUNTRY? USA	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeper at		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) PENNA.			
13. FATHER'S NAME JOHN RILEY				14. MOTHER'S MAIDEN NAME MARGARET HOOPENGARDNER			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. none		17. INFORMANT Wm. Goebel		Address Cumberland, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 40 days DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)				Myocardial Failure		INTERVAL BETWEEN ONSET AND DEATH 4 days	
				Chronic Myocarditis		Unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AN AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. — 19 p. m. —		20d. INJURY OCCURRED White Nat white at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 4/25/57, 19, to 4/25/57, 19, that I last saw the deceased alive on 4/25/57, 19, and that death occurred at 7:30 AM, from the causes and on the date stated above. ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) R. J. Williams, M.D.						ADDRESS (Street, city or town, state) Cumberland, Md. DATE SIGNED 4/25/57	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/27/57		22c. NAME OF CEMETERY OR CREMATORIUM Rose Hill Cemetery		22d. LOCATION (City, town, or county) Cumberland, Md. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE H. Lee Silcox		ADDRESS Cumberland, Md.		24a. REC'D BY REGISTRAR H. Lee Silcox		24b. REGISTRAR'S SIGNATURE H. Lee Silcox	

BUREAU V. S.

PR - 1957

REGEV E D

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3578

CERTIFICATE OF DEATH

Reg. Dist. No.

03555

1. PLACE OF DEATH a. COUNTY Allegany			MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institutional, Residence before admission) a. STATE Md.			b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg			c. LENGTH OF STAY IN 1b			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg			d. STREET ADDRESS Centennial St. Ext.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MINERS						d. STREET ADDRESS			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Thomas			First	Middle	Last	4. DATE OF DEATH	Month	Day	Year			
						April 24	1957					
5. SEX M		6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 24, 1957			9. AGE (In years lost birthday) yrs. 41	10. IF UNDER 1 YEAR Months 7	Days 1	Hour 11	Min. 51	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country)			12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME Richard Goldsworthy			14. MOTHER'S MAIDEN NAME Ellen Devlin			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. 17. INFORMANT Richard Goldsworthy Centennial St. Ext. Frostburg, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			DUE TO Premature birth (7 mos.)			INTERVAL BETWEEN ONSET AND DEATH 9 hrs.						
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b)			DUE TO (c)									
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Mother had 2+ albums throughout pregnancy									19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Hour a. m. p. m. 19			Month, Day, Year 4-24	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) Frostburg, Md.	(County) Allegany	(State) Md.
21. I certify that I attended the deceased from 4-24 , 1957, to 4-24 , 1957, that I last saw the deceased alive on 4-24 , 1957, and that death occurred at INSP M, from the causes and on the date stated above.						ADDRESS (State, city or town, state) Frostburg, Md.			DATE SIGNED 4/24/57			
ACTUAL SIGNATURE H.C. Dietl			M.D.									
PHYSICIAN'S NAME (Type) H.C. Dietl, M.D.												
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL			22b. DATE THEREOF 4-24-57			22c. NAME OF CEMETERY OR CREMATORIAL St. Michael's Cemetery			22d. LOCATION (City, town, or county) Frostburg, Md.			
23. FUNERAL DIRECTOR'S SIGNATURE Paul H. Winters			ADDRESS Hafer Funeral Home 3 E. Main, Frostburg, Md.			24a. REC'D BY REGISTRAR 4-24-57			24b. REGISTRAR'S SIGNATURE Mr. Maurice N. R.			

HOSPITAL OR ATTENDANT PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the death certificate.

VS A1S (4)
15M 9/55

BUREAU V.

APR 29 1957

RECEIVED

3541

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH a. COUNTY ALLEGANY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE MARYLAND		b. COUNTY ALLEGANY		
b. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) CUMBERLAND, MD		c. LENGTH OF STAY IN 1b 2 1/2 HRS.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		d. STREET ADDRESS 928 KENT AVE.,		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL MEMORIAL & WARWICK AVES.,				d. STREET ADDRESS 928 KENT AVE.,		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) CHARLES		First CHARLES	Middle EDWARD	Last HAST	4. DATE OF DEATH APRIL 12 1957	Month APRIL	Day 12	Year 1957
5. SEX MALE		6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JUNE 25, 1913	9. AGE (In years last birthday) 43	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Days 0	12. Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Spinner		10b. KIND OF BUSINESS OR INDUSTRY Textile Plant		11. BIRTHPLACE (State or foreign country) CUMBERLAND, MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME EDWARD HAST		14. MOTHER'S MAIDEN NAME BLANCHE JAY						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Type, no. or unknown) No		16. SOCIAL SECURITY NO. 214-07-4352		17. INFORMANT Lillian Hast		Address 928 Kent Ave.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]						INTERVAL BETWEEN ONSET AND DEATH 1 hr.		
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Acute Coronary Occlusion						
DUE TO								
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost.		(b) Hypertensive Cardio-vasular Disease						
(c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. MEDICAL CERTIFICATION Diabetes Mellitus		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)						
20a. ACCIDENT WAS <input type="checkbox"/> UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour a.m. p.m.		Month 19	Doy. While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) CUMBERLAND	(County) MARYLAND	(State) MARYLAND
21. I certify that I attended the deceased from March 19, 1957 to April 19, 1957 that I last saw the deceased alive on April 12, 1957 , and that death occurred at 9:45 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 158 Virginia Ave., Cumberland, Md. DATE SIGNED W.B. Frank, M.D.								
ACTUAL SIGNATURE <i>O. G. Himmelwright</i>		PHYSICIAN'S (NAME & TYPE) O. G. HIMMELWRIGHT						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-16-57		22c. NAME OF CEMETERY OR CREMATORIAL Hillcrest Burial Park		22d. LOCATION (City, town, or county) (State) CUMBERLAND, MD.		
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli		ADDRESS CUMBERLAND, MD.		24a. REC'D BY REGISTRAR W.B. Frank, M.D.		24b. REGISTRAR'S SIGNATURE W.B. Frank, M.D.		

BUREAU V. S.

APR 17

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										03558	
3579 CERTIFICATE OF DEATH										Reg. Dist. No. 9	
1. PLACE OF DEATH a. COUNTY Allegany MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg 45 minutes					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)						
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Miner's Hospital					d. STREET ADDRESS 90 Washington St.					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First Richard	Middle James	Last Hawkins	4. DATE OF DEATH April 3, 1957		Month	Day	Year		
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> b. DATE OF BIRTH WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> March 27th, 1911		9. AGE (In years lost birthday) 46 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Foreman, Spin. Dept.					10b. KIND OF BUSINESS OR INDUSTRY Celanese Corp.		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Richard Hawkins					14. MOTHER'S MAIDEN NAME Margaret Hanna						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? Yes or no or unknown (If yes, give war or dates of serv.)					16. SOCIAL SECURITY NO 216-01-8837		17. INFORMANT Mrs. Grace E. Hawkins, Frostburg, Md.			90 Washington St.,	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO (c)					acute myocardial infarction Coronary insufficiency					INTERVAL BETWEEN ONSET AND DEATH 2 hrs 7	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.					20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <u>Apr. 3</u> , 1957, to <u>Apr. 3</u> , 1957, that I last saw the deceased alive on <u>Apr. 3</u> , 1957, and that death occurred at <u>10:45 A.M.</u> from the causes and on the date stated above.					ADDRESS (Street, City or town, state)		DATE SIGNED				
ACTUAL SIGNATURE <u>Wom Lane Md</u>					M.D.		<u>Frostburg</u>			<u>Apr. 5 1957</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial					22b. DATE THEREOF Apr. 6th, 57		22c. NAME OF CEMETERY OR CREMATORIUM St. Paul's Cemetery		22d. LOCATION (City, town or county) West Salisbury, Penna. (State)		
23. FUNERAL DIRECTOR'S SIGNATURE Joseph R. Durst, Frostburg, Md.					ADDRESS		24a. REC'D BY REGISTRAR DATE 4-6-57		24b. REGISTRAR'S SIGNATURE <u>Ms. Mary K. Rose</u>		

REGELVÉD
LUNAU V. S.

APR 11 1977

CERTIFICATE OF DEATH

3545

Reg. Dist. No. 4

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 4 hours after death. The bottom copy be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

1. PLACE OF DEATH COUNTY ALLEGANY		2. USUAL RESIDENCE (HOME) OF DECEASED STATE MARYLAND COUNTY ALLEGANY	
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN CUMBERLAND		LENGTH OF STAY (in this place) 35 MIN.	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN RURAL -----CUMBERLAND (If rural give location) STREET ADDRESS RT# 5, WINCHESTER ROAD
HOSPITAL OR INSTITUTION OR STREET ADDRESS SACRED HEART HOSPITAL			
3. NAME OF DECEASED (Type or Print) ADRIAN MARION HOLT		4. DATE (Month) (Day) (Year) OF DEATH APRIL 22, 1957	
5. SEX MALE	6. COLOR OR RACE WHITE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) MARRIED	8. DATE OF BIRTH MAY 31, 1909
9. AGE last birthday 47 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SHOVEL OPERATOR	
11. BIRTHPLACE (State or foreign country) MARYLAND Corriganville		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME JOSEPH HOLT		14. MOTHER'S MAIDEN NAME JOSEPHINE Retzer	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) NC (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. 214-05-9229	
17. INFORMANT & ADDRESS PT'S CHART		18. MEDICAL CERTIFICATION IMMEDIATE CAUSE (A) <i>acute coronary occlusion</i> ANTECEDENT CAUSE(S) DUE TO <i>atherosclerosis</i> DISEASES OR CONDITIONS, IF ANY, (B) GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)	
19. INTERVAL BETWEEN ONSET AND DEATH 1 hour		20. MEDICAL CERTIFICATION INTERVAL BETWEEN ONSET AND DEATH 1 hour	
II DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <i>acute coronary occlusion</i> ANTECEDENT CAUSE(S) DUE TO <i>atherosclerosis</i> DISEASES OR CONDITIONS, IF ANY, (B) GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <i>None</i>			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20c. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>4-22, 1957</i> to <i>4-22, 1957</i> , that I last saw the deceased alive on <i>4-22, 1957</i> , and that death occurred at <i>4:45 A.M.</i> from the causes and on the date stated above. SIGNATURE <i>W. R. Jones</i>		ADDRESS (Street, city, town, state) <i>Cumberland, Md</i> DATE SIGNED <i>4-22-57</i>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 4/25/57	
24. REG'D BY REGISTRAR DATE <i>4-24-1957</i>		REGISTRAR'S SIGNATURE <i>Walter K. Frank, M.D.</i>	
25. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer, Cumberland, Maryland		ADDRESS	

Colligematti

Ref#

ST4-02-9739

TYPEWRITER

PR 95 1957

DALE

44, MS

Outside of City Limits

O HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page may be retained by the hospital or attending physician.

O FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial/transit Permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3589

CERTIFICATE OF DEATH

03560

Reg. Dist. No.

PLACE OF DEATH a. COUNTY Allegany			MARYLAND			2. USUAL RESIDENCE (Where deceased lived - If institution residence before admission) a. STATE Maryland			b. COUNTY Allegany		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) R. D. # 1 Cumberland, rural			c. LENGTH OF STAY IN 1b			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) R. D. # 1 Cumberland, rural					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crystal Park			d. STREET ADDRESS Crystal Park			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)	First CHARLES	Middle AUGUSTUS	Last HUBBARD	4. DATE OF DEATH April 26	Month Year 19 57	Day	Year				
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 27, 1886	9. AGE (In years last birthday) 70	10. IF UNDER 1 YEAR IF UNDER 24 HRS Months 0	Days 0	Hours 0	Min 0			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Machinist Helper			10b. KIND OF BUSINESS OR INDUSTRY & O Railroad Shops.			11. BIRTHPLACE (State or foreign country) Houtzdale, Pa.			12. CITIZEN OF WHAT COUNTRY? U. S. A.		
13. FATHER'S NAME Peter Hubbard			14. MOTHER'S MAIDEN NAME Bridget McCarthy			Address					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No			16. SOCIAL SECURITY NO. 1 11 11 111			17. INFORMANT Mrs. Charles Hubbard, R. D. # 1 Cumberland					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Convay occlusion									INTERVAL BETWEEN ONSET AND DEATH 3 0 mos		
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. 420.1			(b) Generalized arteriosclerosis								
(c) Convay occlusion									4 yrs		
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	Day	Year	20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) 128 Union St	(County) Cumberland	(State) Md.			
21. I certify that I attended the deceased from 1954 to 4/26/57 that I last saw the deceased alive on 4/14/57 , and that death occurred at M , from the causes and on the date stated above. ADDRESS (Street, city or town, state) George M. Simons, M.D.									DATE SIGNED 7/2/57		
ACTUAL SIGNATURE George M. Simons, M.D.											
PHYSICIAN'S NAME (Type) George M. Simons, M.D.											
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Apr. 29, 1957	22c. NAME OF CEMETERY OR CREMATORIAL Hillcrest Burial Park	22d. LOCATION (City, town, or county) Cumberland, Md.	(State) Md.							
23. FUNERAL DIRECTOR'S SIGNATURE Charles L. George, Cumberland, Md.			ADDRESS Charles L. George, Cumberland, Md.			24a. REC'D BY REGISTRAR Apr. 29, 1957	24b. REGISTRAR'S SIGNATURE W. Hankins, M.D.				

RECEIVED

APR 30 1957

BUREAU V.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03561

1 Within corporate limits VAN ORMER 3546

CERTIFICATE OF DEATH

Reg. Dist. No. 4

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be attached for use as the burial-transit Permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY ALLEGANY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND		b. COUNTY ALLEGANY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 1 HR. 35 MIN.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FROSTBURG		d. STREET ADDRESS 65 WASHINGTON STREET		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)		First KENNETH	Middle G.	Last HUGHES	4. DATE OF DEATH APRIL 27 1957	Month APRIL	Day 27	Year 1957
S. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> AUGUST 2, 1913	9. AGE (In years from last birthday) 43	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Days 0	12. IF UNDER 24 HRS Hours 0	13. CITIZEN OF WHAT COUNTRY? U.S.A.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED EXPLOSIVES		10b. KIND OF BUSINESS OR INDUSTRY HERCULES POWDER CO.		11. BIRTHPLACE (State or foreign country) MARYLAND				
13. FATHER'S NAME GRIFFITH HUGHES		14. MOTHER'S MAIDEN NAME ANNIE REESE						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO 216-01-8784		17. INFORMANT MEMORIAL HOSPITAL - CUMBERLAND, MD.		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		a. <i>Arteriosclerosis and Hypertension (part</i>		INTERVAL BETWEEN ONSET AND DEATH 3 years				
Conditions, If any, which gave rise to immediate cause (a), stating the under- lying cause last.		b. <i>Myocardial Infarction, cont.</i>		2				
		c. <i>Diabetes mellitus</i>		25 years				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour a.m. p.m.	Month 19	Day Nat while at work <input type="checkbox"/> at work <input type="checkbox"/>	20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) CUMBERLAND	(County) MONTGOMERY	(State) MD	
21. I certify that I attended the deceased from <i>18 Jan.</i> , 1935, to <i>27 Apr.</i> , 1957, that I last saw the deceased alive on <i>27 Apr.</i> , 1957, and that death occurred at <i>2:20 A.M.</i> from the causes and on the date stated above.				ADDRESS (Street, city or town, state) CUMBERLAND, MD.				
ACTUAL SIGNATURE <i>W. A. Van Ormer</i>	M.D.		DATE SIGNED <i>27 Apr. 57</i>					
PHYSICIAN'S NAME (Type) DR. W. A. VAN ORMER			<i>Cumberlnd, Md.</i>					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF April 29, 1957	22c. NAME OF CEMETERY OR CREMATORIAL Frostburg Memorial Park	22d. LOCATION (City, town, or county) Frostburg, Maryland		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE Durst Funeral Home, Frostburg, Maryland.	ADDRESS	24a. REC'D BY REGISTRAR Date <i>Apr. 29, 1957</i>		24b. REGISTRAR'S SIGNATURE <i>W.R. Franky, M.D.</i>				

RECEIVED

APR 30 1957

BUREAU V. 6

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03562

3547

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH a. COUNTY ALLEGANY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND		b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND, MD.		c. LENGTH OF STAY IN 1b 22 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		d. STREET ADDRESS ROUTE #1	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL MEMORIAL & WARWICK AVES.						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First CLAUDE	Middle T.	Last JETT	4. DATE OF DEATH APRIL 28 1957	Month APRIL	Day 28	Year 1957
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JANUARY 17, 1877	9. AGE (in years last birthday) 80 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days	12. HOURS Hours
10a. USUAL OCCUPATION (Give kind of work done (aving most of working life, even if retired) Retired Office Mgr. Underground Factory		10b. KIND OF BUSINESS OR INDUSTRY FALMOUTH, VIRGINIA		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ELLIOTT JETT		14. MOTHER'S MAIDEN NAME Mary E. SULLIVAN					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unknown)		16. SOCIAL SECURITY NO 214-05-530		17. INFORMANT John Jett		Address Cumberland, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		Arthur Elkins				INTERVAL BETWEEN ONSET AND DEATH 1 year	
(b) DUE TO		Heart Disease				2 yrs	
(c) DUE TO		Familial				3 weeks	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)					
20c. TIME OF INJURY Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>April 27, 1957</u> to <u>April 28, 1957</u> , that I last saw the deceased alive on <u>April 27, 1957</u> , and that death occurred at <u>8:25 A.M.</u> from the causes and on the date stated above.				ADDRESS (Street, city or town, state)		DATE SIGNED April 28/57	
ACTUAL SIGNATURE F. A. G. MURRAY, M.D.							
PHYSICIAN'S NAME (Type) F. A. G. MURRAY							
22a. FUNERAL CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF May 1, 1957		22c. NAME OF CEMETERY OR CREMATORIAL Hillcrest Cem.		22d. LOCATION (City, town, or county) Cumb. Md. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Louis Stein, Inc.		ADDRESS Cumb. Md.		24a. REC'D BY REGISTRAR DATE April 30, 1957		24b. REGISTRAR'S SIGNATURE W. Frank, M.D.	

BUREAU V. A.

May 2 1957

REGIME

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3548

CERTIFICATE OF DEATH

Reg. Dist. No.

03583

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE WEST VIRGINIA b. COUNTY MINERAL	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 2 1/2 HR.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RIDGELEY	
3. NAME OF DECEASED (Type or print) MARY		First MIDDLE SUSAN	4. DATE OF DEATH Month APRIL Day 10 Year 19 57
5. SEX FEMALE		6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH MARCH 13, 1886		9. AGE (In years lost/birthday) 1 yr. Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (State or foreign country) RIDGELEY, W.VA.
12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Saml. DIXON		14. MOTHER'S MAIDEN NAME EMMA Jackson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	17. INFORMANT Address MEMORIAL HOSPITAL, CUMBERLAND, MARYLAND
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 3 hours Cerebral Thrombosis Generalized arteriolysis/knot disease glau-	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>April 18</u> , 1957, to <u>April 18</u> , 1957, that I last saw the deceased alive on <u>April 18</u> , 1957, and that death occurred at <u>6:45 P.M.</u> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) B. M. Schindler, M.D. 41 Everett Cumberland, Md. 4/18/57	
ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) B.M. SCHINDLER, M.D.		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-22-57	22c. NAME OF CEMETERY OR CREMATORIAL Rose Hill cem.
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli		ADDRESS Cumberland, Md.	24a. REC'D BY REGISTRAR W. Frank, M.D. 24b. REGISTRAR'S SIGNATURE

RECEIVED
BUREAU V. S.

APR 24 1957

03564

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 4

Within corporate limits

3549

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)				
Allegany MARYLAND		a. STATE Md. b. COUNTY Allegany				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 14 days				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Memorial Hospital		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland Westernport				
d. STREET ADDRESS XXXXXX		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)	First Mary	Middle L.	Last Lennan			
4. DATE OF DEATH	Month April	Day 27	Year 19 57			
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 13-1879			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home				
11. BIRTHPLACE (State or foreign country) Westemport, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.				
13. FATHER'S NAME Joseph Lennan		14. MOTHER'S MAIDEN NAME Catherine Hanley				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none				
17. INFORMANT Memorial Hospital records		Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]						
PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) Myocardial failure 4221 DUE TO Myocarditis also had Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ?						
DUE TO Arteriosclerosis (c) ?						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL SEASE CONDIT ON GIVEN IN PART I(a) Comminuted introchanteric fracture of right femur						
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) In bathroon, general weakness, fell & injured right leg.				
20c. TIME OF INJURY 5:15 a.m. April 13/57		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) County Home	20f. (City or town) Cumberland	(County) Allegany	(State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>						
ACTUAL SIGNATURE H. V. Deming M.D.		DATE SIGNED April 28-1957				
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF May 1, 1957	22c. NAME OF CEMETERY OR CREMATORI St. Peter's Cemetery	22d. LOCATION (City, town, or county) Westernport, Maryland		
23. FUNERAL DIRECTOR'S SIGNATURE Boal's Funeral Home, Westernport, Maryland.		ADDRESS Boal's Funeral Home, Westernport, Maryland.		24a. REC'D BY REGISTRAR April 29, 1957	24b. REGISTRAR'S SIGNATURE John Tracy, M.D.	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar prior to burial, cremation, or removal.

REGIME

APR 30 1957

BUREAU X-4

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03565

3550

Reg. Dist. No. 4

1. PLACE OF DEATH a. COUNTY Allegany				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Md. b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 35 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		d. STREET ADDRESS 304 Bedford St.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 304 Bedford St.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Ella		First May	Middle Long	Last April	4. DATE OF DEATH Month 17	Day 19	Year 57
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 4-1871		9. AGE (In years last birthday) 85 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Seamstress - Retired		10b. KIND OF BUSINESS OR INDUSTRY Self employed		11. BIRTHPLACE (State or foreign country) Everett Pa.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles Allison				14. MOTHER'S MAIDEN NAME Jennie Chamberlin			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. none		17. INFORMANT (brother) Alvin O. Sutton, Cumberland, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]							
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)							
Myocardial failure							
INTERVAL BETWEEN ONSET AND DEATH Sudden							
4-20-0-0							
DUE TO							
Arteriosclerotic heart disease.							
?							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							
(b)							
DUE TO							
(c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)	(County)	(State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>							
ACTUAL SIGNATURE <i>H.V. Deming M.D.</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> April 17-1957					
EXAMINER'S NAME (Type) H.V. Deming M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF April 20, 1957		22c. NAME OF CEMETERY OR CREMATORIUM Rose Hill Cemetery		22d. LOCATION (City, town, or county) Cumberland, Maryland.	
23. FUNERAL DIRECTOR'S SIGNATURE Louis Stein, Inc., Cumberland, Maryland.		ADDRESS					
		24a. REC'D BY REGISTRAR April 18, 1957					
		24b. REGISTRAR'S SIGNATURE W. Frank, M.D.					

TO DEPUTY MEDICAL EXAMINER: This certificate should be submitted within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU NO. 4

APR 22 1957

RECEIVED

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be retained by the hospital or attending physician. The bottom copy should be detached for use as a burial transit permit. TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy should be detached for use as a burial transit permit.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

03566

CERTIFICATE OF DEATH

3551

Reg. Dist. No. 4

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED						
COUNTY	Allegany	MARYLAND	STATE					
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)	W. Va.					
TOWN	Cumberland,	6 days	COUNTY	Mineral				
HOSPITAL OR INSTITUTION OR STREET ADDRESS	SacredHeart Hospital							
3. NAME OF DECEASED (Type or Print)	(First)	(Middle)	(Last)					
	Elmer		Long					
4. SEX	6 COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	4. DATE OF DEATH	(Month)	(Day)	(Year)
Male	White	Married	July 1, 1908	18	April	25	1957	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)			12. CITIZEN OF WHAT COUNTRY?			
Foreman	Orchard	West Virginia			U.S.A.			
13. FATHER'S NAME	14. MOTHER'S M AIDEN NAME							
John Addison Long	Callie Arbogast							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)	16. SOCIAL SECURITY NO.	17. INFORMANT & ADDRESS						
No	236-50-1310	Patient's Chart.						
18. MEDICAL CERTIFICATION					INTERVAL BETWEEN ONSET AND DEATH			
<p>I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</p> <p>420.1 IMMEDIATE CAUSE (A) acute coronary occlusion</p> <p>ANTECEDENT CAUSE(S) DUE TO (B) coronary heart disease</p> <p>DISEASES OR CONDITIONS, IF ANY, (C) giving rise to the above cause STATING UNDERLYING CAUSE LAST.</p>					1 hour			
					1 month			
<p>II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</p>								
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION			20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)	21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)			21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)				
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED M. While at work <input type="checkbox"/> Not white at work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?						
<p>22. I hereby certify that I attended the deceased from 7-19-1957, to 8-25-1957, that I last saw the deceased alive on 4-25-1957, and that death occurred at 1 P.M. from the causes and on the date stated above.</p> <p>SIGNATURE <i>L. Romig</i> ADDRESS (Street, city, town, state) <i>57 Beech St. Cumberland Md.</i> DATE SIGNED <i>4-26-57</i></p>								
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	DATE THEREOF Apr. 28, 1957	NAME OF CEMETERY OR CREMATORIAL Ebenezer Cemetery	LOCATION (City, town, or county) Romney, W. Va.					
24. REC'D BY REGISTRAR <i>Date 26, 1957</i>	REGISTRAR'S SIGNATURE <i>Winter & Frank, M.D.</i>	25. FUNERAL DIRECTOR'S SIGNATURE <i>Charles. L. George, Cumberland, Md.</i>	ADDRESS					

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RECEIVED
FBI BUREAU W. S.

APR 30 1957

3590

CERTIFICATE OF DEATH

Reg. Dist. No. 6

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Md b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Luké		c. LENGTH OF STAY IN lb 42 Yrs	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 303 Pratt St.		e. STREET ADDRESS 303 Pratt St.	
3. NAME OF DECEASED (Type or print) Lillian		First Myrtle	Middle Maphis
4. DATE OF DEATH April 7		Month April	Day 7
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH Oct. 13, 1893		9. AGE (In years lost birthday) 63 yrs	10. IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10b. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (State or foreign country) Keyser, W. Va.
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Harry Sheetz	
14. MOTHER'S MAIDEN NAME Alberta Walters Address		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no	
16. SOCIAL SECURITY NO.		17. INFORMANT Kenneth Maphis Luke, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a). DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO Arterio-sclerosis (c)		INTERVAL BETWEEN ONSET AND DEATH 1 Year	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Dec. 10, 1956</u> to <u>Apr. 7, 1957</u> , that I last saw the deceased alive on <u>Apr. 2, 1957</u> , and that death occurred at <u>1215 P. M.</u> from the causes and on the date stated above. ACTUAL SIGNATURE <u>Paul R. Wilson</u> M.D. ADDRESS (Street, city or town, state) <u>Piedmont, W. Va.</u> DATE SIGNED <u>Apr. 8, 1957</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/10/57	
22c. NAME OF CEMETERY OR CREMATORIAL Ebanizer Gem.		22d. LOCATION (City, town, or county) (State) Hampshire County-W. Va.	
23. FUNERAL DIRECTOR'S SIGNATURE <u>E. Bral</u>		24a. REC'D BY REGISTRAR ADDRESS Westernport, Md.	
24b. REGISTRAR'S SIGNATURE <u>Jean C Kelly</u>		DATE <u>4-8-57</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

APR 6 1953

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3591

CERTIFICATE OF DEATH

Reg. Dist. No. 03569

1. PLACE OF DEATH a. COUNTY Allegany		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE Md.		b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Barton		c. LENGTH OF STAY IN 1b 80 Yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Barton		d. STREET ADDRESS Railroad St.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Railroad St.				d. STREET ADDRESS Railroad St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Henry	Middle McDonald	Last	4. DATE OF DEATH April	Month 16	Day 16	Year 1957
S. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 15. 1876	9. AGE (in years last birthday) 80 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Miner		10b. KIND OF BUSINESS OR INDUSTRY Coal Mine		11. BIRTHPLACE (State or foreign country) Barton, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John James McDonald		14. MOTHER'S MAIDEN NAME Sara Ann Davis					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT Eileen McDonald		Address Barton, Md.	
no							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. } (b) DUE TO Arterio-sclerosis (c)		Cerebral Hemorrhage		INTERVAL BETWEEN ONSET AND DEATH 16 Days			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) No 14					
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While Not while at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Sept. 15</u> , 1957, to <u>April 16</u> , 1957, that I last saw the deceased alive on <u>Apr. 15</u> , 1957, and that death occurred at <u>12:15 A.M.</u> from the causes and on the date stated above. ACTUAL SIGNATURE <u>Paul R. Wilson</u> M.D.				ADDRESS (Street, city or town, state) <u>Residence, MD</u>		DATE SIGNED <u>4-17-57</u>	
22a. BURIAL CREMATION REMOVAL (Specify) Burial		22b. DATE THEREOF 4/18/57		22c. NAME OF CEMETERY OR CREMATORIUM Laurel Hill		22d. LOCATION (City, town, or county) Moscow (State) Md.	
23. FUNERAL DIRECTOR'S SIGNATURE <u>El Royal</u>		ADDRESS Westernport, Md.		24a. REC'D BY REGISTRAR DATE 4-18-57		24b. REGISTRAR'S SIGNATURE <u>Jean C Kelly</u>	

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-travel Permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

REGELIVE

APR 22 1957

BUREAU K-5

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03570

3592

CERTIFICATE OF DEATH

Reg. Dist. No. 8

1. PLACE OF DEATH a. COUNTY Allegany		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Midland		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Midland	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) Michael		First A.	Middle Mc
4. DATE OF DEATH April 17 1957	Month April	Day 17	Year 1957
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 24, 1874
9. AGE (In years last birthday) 82 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months 0 Days 0 Hours 0 Min 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Miner		10b. KIND OF BUSINESS OR INDUSTRY Coal Mine	
10c. BIRTHPLACE (State or foreign country) Lenaconing, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John P. McGeady		14. MOTHER'S MAIDEN NAME Nora Duggan	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 214-01-6672	
17. INFORMANT John McGeady		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 260X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. Congestive Heart failure "Sem" 2 days	
		(b) DUE TO Arteriosclerosis years	
		(c) DUE TO Diabetes Mellitus years	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April 5, 1957 , to April 17, 1957 , that I last saw the deceased alive on April 12, 1957 , and that death occurred at M. from the causes and on the date stated above. ACTUAL SIGNATURE Leslie R. Miles Jr. M.D. ADDRESS (Street, city or town, state) St. Maria St DATE SIGNED 4-18-57			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/20/57	
22c. NAME OF CEMETERY OR CREMATORIAL ADDRESS St. Michaels Cemetery		22d. LOCATION (City, town, or county) (State) Freastburg, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE George Eickhern		24a. REC'D. BY REGISTRAR DATE 4/20/57	
		24b. REGISTRAR'S SIGNATURE Jeanette M. Bond	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 shall be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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DEALER

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03571

3580

CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH a. COUNTY <i>Anne Arundel</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>MARYLAND</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Easton</i>		c. LENGTH OF STAY IN 1b <i>22 East</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Private</i>		d. STREET ADDRESS <i>1111 15th Street</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>Mary</i>	First	Middle	Last <i>McGuire</i>
4. DATE OF DEATH <i>April 15 1957</i>	Month	Day	Year
5. SEX <i>—</i>	6. COLOR OR RACE <i>—</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>—</i>
9. AGE (In years lost birthday) yrs. <i>—</i>	10. IF UNDER 1 YEAR Months <i>—</i>	11. IF UNDER 24 HRS Days <i>—</i>	12. IF UNDER 24 HRS Hours <i>—</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>—</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>—</i>	11. BIRTHPLACE (State or foreign country) <i>—</i>	12. CITIZEN OF WHAT COUNTRY? <i>—</i>
13. FATHER'S NAME <i>John McGuire</i>	14. MOTHER'S MAIDEN NAME <i>Elvira B. McGuire</i>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>—</i>	16. SOCIAL SECURITY NO. <i>—</i>	17. INFORMANT <i>—</i>	Address <i>—</i>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Paroxysm</i> DUE TO Conditions, If any, which gave rise to immediate cause (b), stating the under- lying cause lost. <i>(b)</i> DUE TO <i>(c)</i>			
INTERVAL BETWEEN ONSET AND DEATH <i>8 hrs.</i>			
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>	20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>—</i> to <i>—</i> , 19 <i>57</i> , to <i>—</i> , 19 <i>57</i> , that I last saw the deceased alive on <i>—</i> , and that death occurred at <i>—</i> PM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>—</i>			
ACTUAL SIGNATURE <i>John McGuire</i>	M.D.	DATE SIGNED <i>April 15 1957</i>	
PHYSICIAN'S NAME (Type) <i>John McGuire</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>4-15-57</i>	22c. NAME OF CEMETERY OR CREMATORIAL <i>St. Michael's Cem.</i>	22d. LOCATION (City, town, or county) (State) <i>Baltimore, Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>John McGuire</i>	ADDRESS <i>624 N. Such</i>	24a. REC'D BY REGISTRAR <i>4-15-57</i>	24b. REGISTRAR'S SIGNATURE <i>John McGuire</i>
VS A15 (4) 15M 9/55			

BUREAU V. S.

2 1957

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

DR. LEWIS

3553 CERTIFICATE OF DEATH

Reg. Dist. No.

03572

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician or funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1. PLACE OF DEATH a. COUNTY ALLEGANY		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		b. COUNTY ALLEGANY	
c. LENGTH OF STAY IN 1b 43 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BARTON RT. #1	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL		d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First FLORENCE		4. DATE OF DEATH Lost MEES	Month APRIL Year 9 1957
5. SEX FEMALE		6. COLOR OR RACE WHITE	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		8. DATE OF BIRTH FEB. 13, 1877	
9. AGE (in years last birthday) 80 yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
10c. BIRTHPLACE (State or foreign country) Maryland		11. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME NELSON MEES		14. MOTHER'S MAIDEN NAME SIGLER, MARY	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Tel. no. or unknown) No		16. SOCIAL SECURITY NO None	
17. INFORMANT MEMORIAL HOSPITAL		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		INTERVAL BETWEEN ONSET AND DEATH	
175X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		Anemia and cachexia	
DUE TO (b)		about 2 years	
DUE TO (c)		Cocciomatosis - generalized	
Cocciomatosis - generalized		about 2 years	
DUE TO (c)		Carcinoma of right ovary	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Feb 25</u> , 1957, to <u>April 9</u> , 1957, that I last saw the deceased alive on <u>April 8</u> , 1957, and that death occurred at <u>2:50 A.M.</u> from the causes and on the date stated above. ACTUAL SIGNATURE <u>Thomas F. Lewis</u> M.D. ADDRESS (Street, city or town, state) <u>5 Washington St</u> DATE SIGNED			
PHYSICIAN'S NAME (Type) <u>Dr. Lewis</u>		Cumberland Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF April 11, 1957	
22c. NAME OF CEMETERY OR CREMATORIUM Meese Family Cemetery		22d. LOCATION (City, town, or county) (State) near Lonaconing, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Boal Funeral Home, Westermport, Maryland.		24a. REC'D BY REGISTRAR April 10, 1957	
		24b. REGISTRAR'S SIGNATURE <u>W.L. Frank, M.D.</u>	

RECEIVED
BUREAU V.

JPR 11 1957

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03573

3554

CERTIFICATE OF DEATH

Reg. Dist. No. 4

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY ALLEGANY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE MARYLAND		b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 2 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FLINTSTONE, MD.		d. STREET ADDRESS ROUTE #2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SACRED HEART HOSPITAL						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First CHARLOTTE	Middle S.	Last MORGAN	4. DATE OF DEATH April 15 1957	Month April	Day 15	Year 1957
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH March 19, 1906	9. AGE (in years less birthday) 51	10. IF UNDER 1 YEAR Months 5	11. IF UNDER 24 HRS Days 0	12. IF UNDER 24 HRS Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sawmill Owner (Retired) and Housewife		10b. KIND OF BUSINESS OR INDUSTRY Penn. Bedford Valley		11. BIRTHPLACE (State or foreign country) Penn. Bedford Valley		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Thomas Miller		14. MOTHER'S MAIDEN NAME Christine Hansel		Address			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? [Yes, no, or unknown] No		16. SOCIAL SECURITY NO		17. INFORMANT		Chart Sacred Heart Hospital	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]						INTERVAL BETWEEN ONSET AND DEATH 2 weeks	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 416x		a. <i>congestive heart failure</i>					
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		b. <i>atherosclerotic heart</i>				b. <i>20 years</i>	
c.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) Coronary Artery Disease					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) 57 Beechwood	(County) Green Street
21. I certify that I attended the deceased from 4-3-1957 to 4-16-1957 , that I last saw the deceased alive on 4-15-1957 , and that death occurred at 57 Beechwood , M., from the causes and on the date stated above.						DATE SIGNED 4-16-1957	
ACTUAL SIGNATURE <i>L. Brings</i>						ADDRESS (Street, city or town, state)	
PHYSICIAN'S NAME (Type) L. Brings, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/18/57		22c. NAME OF CEMETERY OR CREMATORIUM Prosperity Meth. Cemetery		22d. LOCATION (City, town, or county) Allegany County, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer, Cumberland, Maryland.		ADDRESS John J. Hafer, Cumberland, Maryland.		24a. REC'D. BY REGISTRAR April 19, 1957		24b. REGISTRAR'S SIGNATURE W.R. Hafer, M.D.	

BUREAU V. S.

113-54 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03574

3593

CERTIFICATE OF DEATH

Reg. Dist. No. 8

1. PLACE OF DEATH a. COUNTY Allegany		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lonaconing		c. LENGTH OF STAY IN 1b 47 yrs	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Douglas Avenue		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lonaconing	
3. NAME OF DECEASED (Type or print) James Robert Moses		First James	Middle Robert
4. DATE OF DEATH April 14 1957		Lost 47 yrs	Month April
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
8. B. DATE OF BIRTH July 17, 1909		9. AGE (In years from birth) 47 yrs	10. IF UNDER 1 YEAR Months 0
11. BIRTHPLACE (State or foreign country) Lenacening, Maryland		12. IF UNDER 24 HRS Days 0	13. IF UNDER 24 HRS Hours 0
14. CITIZEN OF WHAT COUNTRY? U.S.A.		15. FATHER'S NAME Robert Moses	
16. MOTHER'S MAIDEN NAME Viola Barnes		17. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	
18. SOCIAL SECURITY NO. 214-07-3588		19. INFORMANT Mrs. Robert Moses	
20. ADDRESS Lonacening, Md.		21. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) "Wife" <i>Coronary Occlusion</i>	
22. INTERVAL BETWEEN ONSET AND DEATH 1 hour		23. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
24. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		25. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
26. TIME OF INJURY Hour a.m. p.m. 19		27. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
28. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		29. (City or town) (County) (State)	
30. I certify that I attended the deceased from April 2, 1957 to April 14, 1957 , that I last saw the deceased alive on April 7, 1957 , and that death occurred at 9 a.m. from the causes and on the date stated above. ACTUAL SIGNATURE <i>Leslie R. Miles Jr.</i> PHYSICIAN'S NAME (Type) George Eichhorn		31. ADDRESS (Street, city or town, state) Frostburg, Md.	
32. DATE SIGNED 4/17/57		33. DATE SIGNED 4/17/57	
34. BURIAL, CREMATION, REMOVAL (Specify) Burial		35. DATE THEREOF 4/17/57	
36. NAME OF CEMETERY OR CREMATORIAL Memorial Park		37. LOCATION (City, town, or county) (State) Frostburg, Md.	
38. FUNERAL DIRECTOR'S SIGNATURE George Eichhorn		39. ADDRESS Lonaconing, Md.	
40. REC'D BY REGISTRAR DATE 4/17/57		41. REGISTRAR'S SIGNATURE Jeanette M. Boal	

RECEIVED
BUREAU V.

IPR - 1957

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03575

CERTIFICATE OF DEATH

Reg. Dist. No. 4

Within corporate limits

N

3555

1. PLACE OF DEATH
a. COUNTY

Allegany

MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)

a. STATE

Maryland

b. COUNTY

Allegany

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Cumberland,

c. LENGTH OF STAY IN 1b

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION

777 Fayette St.,

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Cumberland,

d. STREET ADDRESS

777 Fayette St.,

e. IS RESIDENCE
ON A FARM?
YES NO 3. NAME OF
DECEASED
(Type or print)First
MaryMiddle
BerthaLast
Mothersole4. DATE
OF
DEATHMonth
April
24,Day
Year
1957

5. SEX

Female

6. COLOR OR RACE

White

7. MARRIED NEVER MARRIED WIDOWED DIVORCED

8. DATE OF BIRTH

May 31, 1871

9. AGE (In years
last birthday)

85

10. IF UNDER 1 YEAR

Months

11. IF UNDER 24 HRS

Days

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work done
during most of working life, even if retired)

Housewife

10b. KIND OF BUSINESS OR INDUSTRY

Own home

11. BIRTHPLACE (State or foreign country)

Cumberland, Maryland

12. CITIZEN OF WHAT COUNTRY?

U. S.

13. FATHER'S NAME

Jacob Bender

14. MOTHER'S MAIDEN NAME

DesNelda Reinhard

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unknown)
(If yes, give war or date of service)

No,

16. SOCIAL SECURITY NO.

None

17. INFORMANT

Mrs. Frederick A. Puderbaugh 777 Fayette St.,
Cumberland, Md.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

400.2

DUE TO

Condition(s), if any, which
gave rise to immediate
cause (a), stating the under-
lying cause last.

(b)

DUE TO

(c)

cerebral Palsy

INTERVAL BETWEEN
ONSET AND DEATH

year

Hypertension & heart Disease 10 year,

Mild disease of Heart 10 year

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

19. WAS AUTOPSY
PERFORMED?YES NO

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH
(If either, notify medical examiner)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY
Hour a. m.
p. m.

19

19

White

at work

Not white

at work

20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)20f. (City or town)
(County)

(State)

21. I certify that I attended the deceased from 1:20 p.m., 1947, to April 24, 1957, that I last saw the deceased
alive on April 13, 1957, and that death occurred at 2:40 A.M. from the causes and on the date stated above.

ADDRESS (Street, city or town, state)

DATE SIGNED

ACTUAL
SIGNATURE

F. A. G. Murray M. D. Narrows Park, Cumberland, Md.

PHYSICIAN'S
NAME (Type)

F. A. G. Murray M. D.

LaValle

Cumberland, Md.

22a. BURIAL, CREMATION,
REMOVAL (Specify)

Burial

22b. DATE THEREOF

4/27/57

22c. NAME OF CEMETERY OR CREMATORI

S. S. Peter & Paul's

22d. LOCATION (City, town, or county)

(State)

Cumberland, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE

Charles L. George Cumberland, Maryland

ADDRESS

24a. REC'D BY REGISTRAR

DATE

24b. REGISTRAR'S SIGNATURE

W. F. Gandy, M. D.

BUREAU V. 2

APR 29 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Within corporate limits

3556

CERTIFICATE OF DEATH

03576

Reg. Dist. No. 4

HOSPITAL OR HLT. PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be attached for use as the burial-transit Permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY ALLEGANY		2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		b. COUNTY ALLEGANY	
c. LENGTH OF STAY IN 1b 35 MIN.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL		d. STREET ADDRESS 7 1/423 BEALL STREET	
e. IS RESIDENCE ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) MINNIE		First L.	Middle MULLIN
4. DATE OF DEATH APRIL 25		Month APRIL	Day 25
5. SEX FEMALE		6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH MARCH 11, 1886		9. AGE (in years last birthday) 77 yrs	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or Foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME HIRAM M. LITTLE		14. MOTHER'S MAIDEN NAME CATHERINE HERPICH	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT MEMORIAL HOSPITAL - CUMBERLAND, MARYLAND		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 443 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 2 hours.	
Cerebral Vascular Accident Hyper tension Cardi Vascula Disease.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> TO CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED White Not white at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>April</u> , 1957, to <u>April</u> , 1957, that I last saw the deceased alive on <u>April 25, 1957</u> , and that death occurred at <u>1:00 A.M.</u> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) M.D. 133 Virginia Ave., Cumberland, Md.	
ACTUAL SIGNATURE <u>Beth Himmelwright</u>		DATE SIGNED 4/26/57.	
PHYSICIAN'S NAME (Type) DR. OVERTON HIMMELWRIGHT			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/27/57	
22c. NAME OF CEMETERY OR CREMATORIAL Rose Hill Mausoleum		22d. LOCATION (City, town, or county) Cumberland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer, Cumberland, Maryland		24a. REC'D BY REGISTRAR DATE April 27, 1957	
		24b. REGISTRAR'S SIGNATURE John J. Hafer, M.D.	

BUREAU V. C

APR 9 1957

RECEIVED

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03577

Reg. Dist. No. 4

3557

1. PLACE OF DEATH a. COUNTY Allegany		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Md.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		b. COUNTY Allegany			
c. LENGTH OF STAY IN 1b 1/2 hr.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Old Town			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Memorial Hospital		d. STREET ADDRESS /			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)	First Ronald	Middle Charles	Last Nixon		
4. DATE OF DEATH April	Month Month	Day 27	Year 1957		
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 20-1939		
9. AGE (In years last birthday) 18 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	12. IF UNDER 24 HRS. Hours		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student	10b. KIND OF BUSINESS OR INDUSTRY School	11. BIRTHPLACE (State or foreign country) Cumberland, Md.	12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Charles Nixon	14. MOTHER'S M AIDEN NAME Pauline Crabtree	Address			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no	16. SOCIAL SECURITY NO. 214-36-6686	17. INFORMANT (father) Charles Nixon, Old Town, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)					
Intrathoracic hemorrhage Crushed Crushed chest (left side) INTERVAL BETWEEN ONSET AND DEATH 1 hr.					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERM DISEASE CONDITION GIVEN IN PART I (a) 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH. Driver lost control of car & hit a tree in W.Va.					
20c. TIME OF INJURY Month, Day, Year Hour 9.15 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Highway, near Green Spring	20f. (City or town) Green Spring	(County) W. Va.	(State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>					
ACTUAL SIGNATURE H. V. Deming M.D.	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			DATE SIGNED April 28-1957	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF April 30, 1957	22c. NAME OF CEMETERY OR CREMATORIAL Davis Memorial Park	22d. LOCATION (City, town, or county) Cumberland, Maryland	(State)	
23. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer, Cumberland, Maryland.	ADDRESS	24a. REC'D BY REGISTRAR DATE April 29, 1957	24b. REGISTRAR'S SIGNATURE W.R. Franky, M.D.		

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 5 may be retained for your files.
FORWARDED TO THE CHIEF MEDICAL EXAMINER'S OFFICE ALONG WITH FORM MM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-trust permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU Y. S.

APR 30 1957

RECEIVED

Within corporate limits

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-trust permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

03578

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Allegany				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 80 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland						
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1105½ Virginia Avenue		d. STREET ADDRESS 1105½ Virginia Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print)	First Martha	Middle Ellen	Last Orndoff	4. DATE OF DEATH April	Month 6	Day 157	Year			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 5, 1871	9. AGE (In years last birthday) 85 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS Days 0	Hours 0	Min 0		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Winchester, Va.		12. CITIZEN OF WHAT COUNTRY? USA				
13. FATHER'S NAME George Rinker			14. MOTHER'S MAIDEN NAME Eliza Jane Rosenberger							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Miss Mamie Orndoff, Cumberland, Md.		Address				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			INTERVAL BETWEEN ONSET AND DEATH							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO (c)			<i>Chronic Myelosclerosis 4 years</i>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Varices of liver</i>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <i>fall from a chair</i>								
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Cumberland		(County) Allegany	(State) Md.	
21. I certify that I attended the deceased from 4/4/57 , 19, to 4/6/57 , 19, that I last saw the deceased alive on 4/5/57 , 19, and that death occurred at 3:35 P.M. from the causes and on the date stated above.			ADDRESS (Street, city or town, state) Cumberland, Md.						DATE SIGNED 4/8/57	
ACTUAL SIGNATURE <i>O. H. Mulligan</i>		PHYSICIAN'S NAME (Type) M.D.								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Apr. 9, 1957		22c. NAME OF CEMETERY OR CREMATORIUM Asbury Cemetery		22d. LOCATION (City, town, or county) Near Moorefield, W. Va.		(State) W. Va.		
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli, Cumberland, Md.			ADDRESS			24a. REC'D BY REGISTRAR April 9, 1957		24b. REGISTRAR'S SIGNATURE W. G. Gandy, Jr. D.		

REGULY BUREAU V. 8

APR 11 1961

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3581

CERTIFICATE OF DEATH

03579

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Allegany		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg		c. LENGTH OF STAY IN 1b 9 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Zihlman Box T31		d. STREET ADDRESS R. D. No 2 Frostburg		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Miner's Hospital						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) William		First	Middle	Last	4. DATE OF DEATH 4	Month	Day	Year
5. SEX M		6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-25-1885		9. AGE (In years last birthday) 71 yrs	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Miner		10b. KIND OF BUSINESS OR INDUSTRY Coal Mines		11. BIRTHPLACE (State or foreign country) Zihlman		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME John Porter				14. MOTHER'S MAIDEN NAME Nahila Crowe				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Wm. N. Porter Frostburg, Md.		R. D. #2 Box 131		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 1118 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH at least 1 yr.		
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Eckhart		20f. (City or town) Eckhart	(County)	(State)
21. I certify that I attended the deceased from <u>APRIL 14</u> , 1956, to <u>APRIL 2</u> , 1957, that I last saw the deceased alive on <u>APRIL 3</u> , 1957, and that death occurred at <u>2:12 A.M.</u> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) M.D. 45 BROADWAY, FROSTBURG, MD 4/3/57						
ACTUAL SIGNATURE <i>Paul J. Rothstein</i>		DATE SIGNED 1957						
PHYSICIAN'S NAME (Type) MARTIN M. ROTHSTEIN M.D.								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-5-57		22c. NAME OF CEMETERY OR CREMATORIAL Porter Cemetery		22d. LOCATION (City, town, or county) Eckhart		
23. FUNERAL DIRECTOR'S SIGNATURE <i>Paul J. Rothstein</i>		ADDRESS Hafer Funeral Home 23 E. Main Frostburg, Md.		24a. REC'D BY REGISTRAR DATE 4-24-57		24b. REGISTRAR'S SIGNATURE <i>Dorothy N. Rothstein</i>		

SURVEAU V.

APR 29 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03580

3559

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH a. COUNTY Allegany		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 4 months		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		d. STREET ADDRESS 204 Virginia Ave.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 204 Virginia Ave.				d. STREET ADDRESS 204 Virginia Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Montary	Middle Puffinburger	Last 	4. DATE OF DEATH April 19	Month April	Day 19	Year 1957
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH March 23, 1878	9. AGE (In years last birthday) 79	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	12. IF UNDER 24 HRS. Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working-life, even if retired) Retired Laborer		10b. KIND OF BUSINESS OR INDUSTRY Saw Mill		11. BIRTHPLACE (State or foreign country) Harrisonburg, Va.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Puffinburger		14. MOTHER'S MAIDEN NAME Elizabeth Shade					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. None		17. INFORMANT Waldo Puffinburger, Cumberland, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause, if any. (b) DUE TO		Malaria				INTERVAL BETWEEN ONSET AND DEATH 3 wks.	
(b) DUE TO		Arteriosclerotic Cerebro-Vascular Disease				4 yrs	
(c)							
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Feb. 15, 1957 to Apr. 19, 1957 that I last saw the deceased alive on Apr. 18, 1957 , and that death occurred at 7:30 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Clay E. Durrett		ADDRESS (Street, city or town, state) 236 V. G. Lane, Cumberland, Md.					
PHYSICIAN'S NAME (Type) Clay E. Durrett		DATE SIGNED Apr. 22, 1957					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-23-57		22c. NAME OF CEMETERY OR CREMATORIUM Wesley Chapel		22d. LOCATION (City, town, or county) (State) Points, W. Va.	
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli, Cumberland, Md.		ADDRESS		24a. REC'D BY REGISTRAR DATE Apr. 22, 1957		24b. REGISTRAR'S SIGNATURE W. R. Frantz, M. D.	

TO HOSPITAL OR ATTENDIN PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V.

APR 24 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3594

CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH a. COUNTY Allegany		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Borden Mines		c. LENGTH OF STAY IN 1b Lifetime		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg, Md.		d. STREET ADDRESS R.D. #2, Box 183			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION R.J. #2, Frostburg, Md.				d. STREET ADDRESS R.D. #2, Box 183		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) JAMES		First	Middle	Last	4. DATE OF DEATH 4	Month	Day	Year	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-10-1900	9. AGE (In years last birthday) 56 yrs	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Coal Miner		10b. KIND OF BUSINESS OR INDUSTRY Coal Mines		11. BIRTHPLACE (State or foreign country) Zihlman		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME James Rankin		14. MOTHER'S MAIDEN NAME Edith Shoemake							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) None		16. SOCIAL SECURITY NO. 216-30-2085		17. INFORMANT R.D. #2, Box 183					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 452X		DUE TO <i>Aneurism Left Renal artery</i>		INTERVAL BETWEEN ONSET AND DEATH 1 mo					
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO									
(c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Frostburg		20f. (City or town) Frostburg		(County)	(State)
21. I certify that I attended the deceased from Mar 22, 1957 to Apr 22, 1957 that I last saw the deceased alive on Apr 20, 1957 , and that death occurred at 1:20 P.M. from the causes and on the date stated above.									
ACTUAL SIGNATURE WOMC Lane		M.D.		ADDRESS (Street, city or town, state) Frostburg		DATE SIGNED Apr 24, 1957			
PHYSICIAN'S NAME (Type) WOMC Lane MD									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-25-1957		22c. NAME OF CEMETERY OR CREMATORIAL Frostburg Memorial Park		22d. LOCATION (City, town, or county) Frostburg		(State) Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Hafer funeral Home		ADDRESS 23 E. Main Street		23e. REC'D BY REGISTRAR 4-25-1957		24b. REGISTRAR'S SIGNATURE Henry H. Roe			

BUREAU V. A

APR 29 1957

REGULATIVE

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03582

3595

CERTIFICATE OF DEATH

Reg. Dist. No.

4

1. PLACE OF DEATH
a. COUNTY

Allegany

MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)

STATE
Maryland

b. COUNTY

Allegany

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Cumberland, rural

c. LENGTH OF STAY IN 1b

34 years

d. NAME OF HOSPITAL (If not in hospital, give street address)
OR INSTITUTION

Baltimore Pike, R.F.D. #2

3. NAME OF
DECEASED
(Type or print)First
EdithMiddle
MayLast
Rice4. DATE
OF
DEATHMonth
AprilDay
10
Year
1957

5. SEX

Female

6. COLOR OR RACE

White

7. MARRIED NEVER MARRIED WIDOWED DIVORCED

8. DATE OF BIRTH

5/19/91

9. AGE (In years
lost birthday)
65

10. yn

11. IF UNDER 1 YEAR
Months

Days

12. IF UNDER 24 HRS
Hours

Min.

10a. USUAL OCCUPATION (Give kind of work done
during most of working life, even if retired)

Housekeeper at

10b. KIND OF BUSINESS OR INDUSTRY

Home

11. BIRTHPLACE (State or foreign country)

Avilton Md.

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

?

Robison

14. MOTHER'S MAIDEN NAME

Katherine Robison

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unknown)

No

16. SOCIAL SECURITY NO.

None

17. INFORMANT

Address

Carl Rice Cumberland, Md.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

Hemiplegia

INTERVAL BETWEEN
ONSET AND DEATH
3-5 mon

DUE TO

Conditions, if any, which
gave rise to immediate
cause (a), stating the under-
lying cause last.

(b)

Atherosclerosis

?

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY
PERFORMED?YES NO

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY

Month

Day

Year

Hour

a. m.

p. m.

20d. INJURY OCCURRED

White Not white

at work at work 20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I attended the deceased from 2/6/57, 1957, to 4/7/57, 1957, that I last saw the deceased
alive on 4-7-57, and that death occurred on 4-7-57, from the causes and on the date stated above.ACTUAL
SIGNATURE

W.R. Hodges

M.D.

ADDRESS (Street, city or town, state)

DATE SIGNED

PHYSICIAN'S
NAME (Type)

W.R. Hodges, M.D.

22a. BURIAL, CREMATION,
REMOVAL (Specify)

Burial

22b. DATE THEREOF

4/13/57

22c. LOCATION (City, town, or county)

(State)

Cumberland, Md.

23. FUNERAL DIRECTOR'S SIGNATURE

H. Lee Silcox Cumberland, Md.

ADDRESS

24a. REC'D BY REGISTRAR

24b. REGISTRAR'S SIGNATURE

April 11, 1957 W.R. Hodges, M.D.

RECEIVED
BUREAU V. 8

APR 12 1957

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03583

3560 CERTIFICATE OF DEATH

Reg. Dist. No. 4

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be retained for use as the burial-transit Permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY ALLEGANY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN lb 11 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FROSTBURG	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL, MEMORIAL & WARWICK AVES.		d. STREET ADDRESS 77 WASHINGTON STREET		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) EMMA		First MIDDLE M	Last RICE	4. DATE OF DEATH APRIL 27	Month Day Year 1957
5. SEX FEMALE		6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JANUARY 27, 1881	9. AGE (In years lost birthday) 76 yr. 10. IF UNDER 1 YEAR Months Days Hours Min. 11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) FROSTBURG, MARYLAND	
13. FATHER'S NAME ADAM KRAUSS		14. MOTHER'S MAIDEN NAME ANNA VOGTMAN		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Memorial Hospital	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		INTERVAL BETWEEN ONSET AND DEATH 1954			
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)		Arteriosclerotic Cardiovascular disease			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Cholecystitis & Cholelithiasis		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED White Not white at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>11.29.1956</u> to <u>4.27.1957</u> that I last saw the deceased alive on <u>4.27.1957</u> , and that death occurred at <u>1:20 P.M.</u> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) W. J. Williams, M.D. Frostburg, Maryland			
ACTUAL SIGNATURE		DATE SIGNED W. J. Williams, M.D. Frostburg, Maryland			
PHYSICIAN'S NAME (Type) W.F. WILLIAMS					
22a. BUR AL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF April 30, 1957		22c. NAME OF CEMETERY OR CREMATORIAL Zion Evangelical & Reformed Cen., Frostburg, Maryland	
22d. LOCATION (City, town, or county) (State)					
23. FUNERAL DIRECTOR'S SIGNATURE Durst Funeral Home, Frostburg, Maryland.		ADDRESS		24a. REC'D BY REGISTRAR DATE	
				24b. REGISTRAR'S SIGNATURE W. J. Frank, M.D.	

BUREAU V. S.

APR 30 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03584

Reg. Dist. No. 4

3596

1.
Outside of
a
Funeral
Home
or removal.

1. PLACE OF DEATH
a. COUNTY

Allegany

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Cumberland

c. LENGTH OF STAY IN 1b

15 yrs

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

**Rt. #4 Old Town Road *D.O.A.
the Memorial Hospital**

3. NAME OF
DECEASED
(Type or print)

Charles

Emory

Robinette

4. DATE
OF
DEATH

April 7

1957

5. SEX

white

6. COLOR OR RACE

WIDOWED

7. MARRIED NEVER MARRIED

8. DATE OF BIRTH

Aug. 29-1900

9. AGE (in years
last birthday)

56

10. IF UNDER 1 YEAR
Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done
during most of working life, even if retired)

Carman helper

10b. KIND OF BUSINESS OR INDUSTRY

B&O R.Ry.

11. BIRTHPLACE (State or foreign country)

Cumberland, Md.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Charles Robinette

14. MOTHER'S MAIDEN NAME

Laura Valentine

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unknown)

16. SOCIAL SECURITY NO.

17. INFORMANT

Address

220-10-0622 (brother) Geo. A. Robinette, Cumberland, Md.

INTERVAL BETWEEN
ONSET AND DEATH

sudden

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY;
IMMEDIATE CAUSE (a)

Coronary occlusion

420.1

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause first.

DUE TO

(b)

Coronary sclerosis

DUE TO

(c)

?

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY
PERFORMED?

YES NO

20a. EXTERNAL CAUSE WAS
PRIMARY or CONTRIBUTING CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY
Month, Day, Year
Hour
o. m.
p. m.

20d. INJURY OCCURRED
While
at work Not while
at work

20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I took charge of the remains described above, held an Autopsy Inspection Inquiry and find that
death resulted from: Natural causes Accident Suicide Homicide Undetermined cause

ACTUAL
SIGNATURE

H. V. Denning M.D.

DATE SIGNED

M.D. CHIEF MEDICAL EXAMINER

ASSISTANT MEDICAL EXAMINER

DEPUTY MEDICAL EXAMINER

April 8-1957

22a. BURIAL, CREMATION,
REMOVAL (Specify)

4-10-57

22c. NAME OF CEMETERY OR CREMATORY

22d. LOCATION (City, town, or county)

(State)

Cumberland, Md.

23. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

James F. Scarpelli, Cumberland, Md.

24a. REC'D BY REGISTRAR

April 9, 1957

24b. REGISTRAR'S SIGNATURE

W. R. Frank, M.D.

1
Outside of
a
Funeral
Home
or removal.

Outside of
a
Funeral
Home
or removal.

rural
at

at</

BUREAU V. S.

APR 11 1957

RECEIVED

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03585

3561

CERTIFICATE OF DEATH

Reg. Dist. No. 4

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 and 5 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY ALLEGANY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND		b. COUNTY ALLEGANY				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 5 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		d. STREET ADDRESS 105 SOUTH LEE ST.,				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL MEMORIAL & WARWICK AVES.,				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)		First RANDOLPH	Middle	Last ROBINETTE	4. DATE OF DEATH	Month APRIL	Day 28	Year 1957		
5. SEX MALE		6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH AUGUST 18, 1892	9. AGE (In years last birthday) 64	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	12. IF UNDER 24 HRS. Hours 0	13. IF UNDER 24 HRS. Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sheet metal & Pipe Fitter		10b. KIND OF BUSINESS OR INDUSTRY Railroad		11. BIRTHPLACE (State or foreign country) CUMBERLAND, MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.				
13. FATHER'S NAME ELI ROBINETTE		14. MOTHER'S MAIDEN NAME MARTHA WILSON								
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Mar 1.		16. SOCIAL SECURITY NO. 705-09-9643		17. INFORMANT Mrs. Amanda Robinette		Address Cumberland, Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)								INTERVAL BETWEEN ONSET AND DEATH		
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		<i>Myocardial & hypertension</i>						<i>48 hrs.</i>		
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		<i>Three episodes of Myocardial infarction</i>						<i>3 months</i>		
DUE TO (b)										
(c)										
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)								
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Cumberland		(County) Cumberland	(State) Md.	
21. I certify that I attended the deceased from 8/15/57 , 19 19 , to 4/28/57 , 19 19 , that I last saw the deceased alive on 4/27/57 , 19 19 , and that death occurred at 7:30 A.M. from the causes and on the date stated above.								ADDRESS (Street, city or town, state) Cumberland	DATE SIGNED 4/28/57	
ACTUAL SIGNATURE <i>R. J. Williams</i>		M.D.								
PHYSICIAN'S NAME (Type) R. J. WILLIAMS										
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-30-1957		22c. NAME OF CEMETERY OR CREMATORIAL Hillcrest Cem.		22d. LOCATION (City, town, or county) Cumberland, Md.		(State) Md.		
23. FUNERAL DIRECTOR'S SIGNATURE Charles L. George		ADDRESS Cumberland, Md.						24a. REC'D BY REGISTRAR April 29, 1957		24b. REGISTRAR'S SIGNATURE W. Frank M.D.

RECEIVED
BUREAU X-2

APR 30 1957

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. The registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. The registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3582

CERTIFICATE OF DEATH

Reg. Dist. No.

03586

1. PLACE OF DEATH a. COUNTY Allegany		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland		b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg		c. LENGTH OF STAY IN 1b 10 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg		d. STREET ADDRESS 111 High St.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Miners Hospital						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) ARTHUR	First	Middle E.	Last ROBISON	4. DATE OF DEATH April	Month 15	Day 15	Year 1957
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Apr. 1, 1891	9. AGE (In years from birthday) 66	10. IF UNDER 1 YEAR Months 6	11. IF UNDER 24 HRS. Days 0	12. IF UNDER 24 HRS. Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired - calendar room		10b. KIND OF BUSINESS OR INDUSTRY Kelly-Spgfd. Tire		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joshua Robison		14. MOTHER'S MAIDEN NAME Mary A. Sinnet		Address			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)		16. SOCIAL SECURITY NO 214-05-9886		17. INFORMANT Mrs. Martha Hewitt, Frostburg, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 5711 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause, lost. (b) DUE TO Influs (c) DUE TO Subacute Colitis						INTERVAL BETWEEN ONSET AND DEATH 10 minutes	
						4 days	
						3 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 48 Broadway, Frostburg, Md.		20f. (City or town) Frostburg	(County) (State) (Md.)
21. I certify that I attended the deceased from March 24, 1957 to April 15, 1957 , that I last saw the deceased alive on April 15, 1957 , and that death occurred at 2:30 P.M. from the causes and on the date stated above.						ADDRESS (Street, city or town, state) 48 Broadway, Frostburg, Md.	DATE SIGNED 4/16/57
ACTUAL SIGNATURE Hilda Jane Walters, M.D.							
PHYSICIAN'S NAME (Type) Hilda Jane Walters, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-17-57		22c. NAME OF CEMETERY OR CREMATORIUM St. Michaels Cemetery		22d. LOCATION (City, town, or county) Frostburg, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE J. R. Durst, Frostburg, Md.		ADDRESS Frostburg, Md.		24a. REC'D BY REGISTRAR 4-17-57		24b. REGISTRAR'S SIGNATURE Mrs. Grace A. Log	

RECEIVED
APR 22 1957

BUREAU N.Y.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Within corporate limits:

3562

CERTIFICATE OF DEATH

Reg. Dist. No. 4

13587

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE	
Allegany MARYLAND		Maryland Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL and give nearest town	c. LENGTH OF STAY IN 1b Life.	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland Md	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 811 Braddock Rd.		d. STREET ADDRESS 811 Braddock Rd.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Carl	Middle F.	Last Schmitz
4. DATE OF DEATH	Month Jul.	Day 28	Year 1957
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug 15, 1891
9. AGE (In years from birthday) 65 yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Real Estate salesman	11. KIND OF BUSINESS OR INDUSTRY Real Estate	12. BIRTHPLACE (State or foreign country) Cumberland Md.
13. FATHER'S NAME Charles A. Schmitz	14. MOTHER'S MAIDEN NAME Mary E. Messman	12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give rank and date of service) Yes. WWT	16. SOCIAL SECURITY NO.	17. INFORMANT Mrs. Ester Schmitz	Address Cumb Md.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		INTERVAL BETWEEN ONSET AND DEATH	
420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		Coronary Occlusion	
(b) DUE TO Anteriosclerosis			
(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Hour o. m. p. m.	20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
19			
21. I certify that I attended the deceased from January 1957 to April 29, 1957, that I last saw the deceased alive on April 27, 1957, and that death occurred at 12:30 AM, from the causes and on the date stated above.			
ACTUAL SIGNATURE PHYSICIAN'S NAME (Type)	ADDRESS (Street, city or town, state) 452 N. Centre St. DATE SIGNED Cumberland Md. 4/30/57		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF May 1957	22c. NAME OF CEMETERY OR CREMATORIAL SS Peter + Paul	22d. LOCATION (City, town, or county) Cumb Md. (State)
23. FUNERAL DIRECTOR'S SIGNATURE Louis Stein Inc.	ADDRESS Cumb Md.	24a. REC'D BY REGISTRAR Aug 1957	24b. REGISTRAR'S SIGNATURE W. Ross Cameron, M.D. Acting Deputy State Health Officer

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

MAY 3 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH--BALTIMORE, 18

03588

3597

CERTIFICATE OF DEATH

Reg. Dist. No. 4

PLACE OF DEATH
D. COUNTY

Allegany

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write
RURAL and give nearest town)

Rural Germantown

c. LENGTH OF STAY IN lb

d. NAME OF HOSPITAL (If not in hospital, give street address)
OR INSTITUTION

RE #6 Box 66

2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission)

d. STATE

Maryland

b. COUNTY

Allegany

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Rural Germantown

d. STREET ADDRESS

RE #6 Box 66

e. IS RESIDENCE
ON A FARM?
YES NO 3. NAME OF
DECEASED
(Type or print)

5. SEX

6. COLOR OR RACE

Male White

7. MARRIED NEVER MARRIED WIDOWED DIVORCED

8. DATE OF BIRTH

9. AGE (in years
lost birthday)10a. USUAL OCCUPATION (Give kind of work done
during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, never unknown)

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

DUE TO

Conditions, if any, which
gave rise to immediate
cause (a), stating the under-
lying cause lost.

(b)

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

19. WAS AUTOPSY
PERFORMED?YES NO 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH
(If either, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year

Hour a.m.

p.m.

20d. INJURY OCCURRED

While at work Not while at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I attended the deceased from

Jan. 1956, to

April 7, 1957, that I last saw the deceased

alive on April 8, 1957, and that death occurred at 1:30 A.M. from the causes and on the date stated above.

ADDRESS (Street, city or town, state)

DATE SIGNED

ACTUAL
SIGNATURE

F. Alan G. Murray, M.D.

In Valo Md

PHYSICIAN'S
NAME (Type)

F. Alan G. Murray, M.D.

In Valo Md

22a. BURIAL, CREMATION,
REMOVAL (Specify)

Burial 4/10/1957

22b. DATE THEREOF

4/10/1957

22c. NAME OF CEMETERY OR CREMATORI

St. Peter & Pauls

22d. LOCATION (City, town, or county)

Cumberland

(State)

Md.

23. FUNERAL DIRECTOR'S SIGNATURE

Louis Stein Inc.

Cumb. Md.

4/10/1957

ADDRESS

4/10/1957

24a. REC'D BY REGISTRAR

4/10/1957

W.H. Frank, M.D.

REGISTRAR'S SIGNATURE

W.H. Frank, M.D.

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BUFLAY A. G.

APR 11 1957

REGELIVE

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03589

3563

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany			2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Maryland		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland			b. COUNTY Allegany		
c. LENGTH OF STAY IN 1b 5 min.			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Sacred Heart Hospital			d. STREET ADDRESS 305 Mt. View Drive		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)		First Norman	Middle Edward	Last Sell	4. DATE OF DEATH April 16, 1895
5. SEX		6. COLOR OR RACE Male	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH April 16, 1895	9. AGE (In years last birthday) 61
10a. USUAL OCCUPATION (Give kind of work done) 10b. KIND OF BUSINESS OR INDUSTRY (during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY Owner Brick Yard		11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME George Sell (Deceased)			14. MOTHER'S MAIDEN NAME Nellie Sullivan (Deceased)		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. H. H. 1		17. INFORMANT Mrs. Norman Sell, 305 Mt. View Drive	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion INTERVAL BETWEEN ONSET AND DEATH					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion INTERVAL BETWEEN ONSET AND DEATH					
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b)			
20c. TIME OF INJURY Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Cumberland	(County) Md. (State)
21. I certify that I attended the deceased from Jan , 1957, to April , 1957, that I last saw the deceased alive on April 2 , 1957, and that death occurred at 12:15 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 456 N. Centre St., Cumberland, Md. DATE SIGNED 4/7/57					
ACTUAL SIGNATURE Leo H. Ley Jr., M.D.					
22a. PHYSICIAN'S NAME (Type)		22b. DATE THEREOF April 10, 1957			
22c. BURIAL, CREMATION, REMOVAL (Specify) Burial		22d. NAME OF CEMETERY OR CREMATORIAL S. S. Peter & Paul Cem.		22e. LOCATION (City, town, or county) Cumberland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Charles L. George, Cumberland, Md.					
24a. REC'D BY REGISTRAR April 9, 1957		24b. REGISTRAR'S SIGNATURE W. Frank Jr., M.D.			

HOSPITAL OR ATTENDANT PHYSICIAN: This law requires that the death certificate be executed within 4 hours after death: Page 1 and 2 should be filed with the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU X-8

APR 11 1957

CONFIDENTIAL

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03590

Reg. Dist. No. 4

Within corporate limits

3564

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Farm PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to removal.

VS. A15ME(S)
SM 9/55

1. PLACE OF DEATH a. COUNTY		Allegany		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)		a. STATE		Md.		b. COUNTY		Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Cumberland		c. LENGTH OF STAY IN 1b		3 yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Cumberland		d. STREET ADDRESS		1027 Braddock Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		1027 Braddock Road															
3. NAME OF DECEASED (Type or print)		First Charles		Middle		Last Smith		4. DATE OF DEATH		Month April		Day 2		Year 19 57			
5. SEX		6. COLOR OR RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years on birthday)		10. IF UNDER 1YEAR Months		11. IF UNDER 24 HRS. Days		12. IF UNDER 24 HRS. Hours			
male		white		WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		Feb. 4-1884		73 yr.									
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?											
retired-employee - Rosenbaum Dept. Store		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?											
13. FATHER'S NAME		Phillip Smith		14. MOTHER'S MAIDEN NAME		Christine Nickel											
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address											
no		214-05-6183		(son) Charles Smith, LaVale, Md.													

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a)		sudden	
Coronary occlusion			
DUE TO			
Conditions, if any, which goe rise to immediate cause (a), stating the underlying cause lost.		?	
(b)			
Coronary sclerosis			
DUE TO			
(c)		?	
Arteriosclerosis			

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	

21. I certify that I took charge of the remains described above, held an Autopsy , Inspection , Inquiry , and find that death resulted from: Natural causes , Accident , Suicide , Homicide , Undetermined cause .

ACTUAL
SIGNATURE *H.V. Deming 2/12* DATE SIGNED

M.D. CHIEF MEDICAL EXAMINER
ASSISTANT MEDICAL EXAMINER
DEPUTY MEDICAL EXAMINER April 2-1957

22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORIUM		22d. LOCATION (City, town, or county)		(State)	
Burial		April 5, 1957		St. Luke's Cemetery		Cumberland		Md.	
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE			
Louis Stein, Inc.		Cumberland, Md.		April 3, 1957		John R. Bentz, M.D.			

BUREAU V. S.

APR 4 1957

REGISTRATION

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3565

CERTIFICATE OF DEATH

03591

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ALLEGANY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND		b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 5 1/2 HR.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL		d. STREET ADDRESS BOULEVARD APARTMENTS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First BABY	Middle BOY	Last SOCKS	4. DATE OF DEATH APRIL 3, 1957	Month APRIL	Day 3	Year 1957
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH APRIL 3, 1957	9. AGE (In years last birthday) yrs. 5	10. IF UNDER 1 YEAR: IF UNDER 24 HRS. Months 5	Days 5	Hours 26
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) CUMBERLAND, MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ROBERT H. SOCKS		14. MOTHER'S MAIDEN NAME EDNA R. FURRY					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT MEMORIAL HOSPITAL, CUMBERLAND, MARYLAND		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): 1774-X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____, 19____, from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____							
ACTUAL SIGNATURE _____							
PHYSICIAN'S NAME (Type) FULLER B. WHITWORTH, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF April 5, 1957		22c. NAME OF CEMETERY OR CREMATORIAL Memorial Hospital		22d. LOCATION (City, town, or county) Cumberland (State) Md	
23. FUNERAL DIRECTOR'S SIGNATURE Memorial Hospital, Cumberland, Md.		ADDRESS 60374 X VO		24e. REC'D BY REGISTRAR April 5, 1957		24f. REGISTRAR'S SIGNATURE W. F. Frantz, M.D.	

DECEIVED
BUREAU V-8

JPR 8 1957

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

103592

3583

CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH
a. COUNTY

Allegany

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Frostburg

c. LENGTH OF STAY IN 1b

10 days

d. NAME OF HOSPITAL (If not in hospital, give street address)
OR INSTITUTION

Miners Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission)
a. STATE

Maryland

b. COUNTY

Allegany

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Frostburg

d. STREET ADDRESS

160 Ormond St.

e. IS RESIDENCE
ON A FARM?
YES NO 3. NAME OF
DECEASED
(Type or print)

First

Middle

Last

4. DATE
OF
DEATHMonth
AprilDay
25, 1957

5. SEX

6. COLOR OR RACE

7.

MARRIED NEVER MARRIED WIDOWED DIVORCED

8. DATE OF BIRTH

9. AGE (In years
less birthday)
66

10. IF UNDER 1 YEAR IF UNDER 24 HRS.

Months Days Hours Min

male

white

Sept. 26, 1890

10a. USUAL OCCUPATION (Give kind of work done
during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Dye House

Celanese Corp.

Frostburg, Md.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Henry Spitznas

14. MOTHER'S MAIDEN NAME

Martha Lemmert

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unknown)
yes

WW I

16. SOCIAL SECURITY NO.

17. INFORMANT

Address

Edna Spitznas, Frostburg, Md.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]

PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a)

44.2 X

DUE TO

Conditions, if any, which
gave rise to immediate
cause (a), stating the under-
lying cause last.

(b)

DUE TO

(c)

INTERVAL BETWEEN
ONSET AND DEATH

4 years,

MEDICAL CERTIFICATION

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY
PERFORMED?YES NO 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH
(If either, notify MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Month, Day, Year
Hour o. m. 19
p. m.20d. INJURY OCCURRED
While
at work Not while
at work 20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I attended the deceased from 4/24, 1957, to 4/24, 1957, that I last saw the deceased
alive on 4/25, 1957, and that death occurred at 5:45 AM, from the causes and on the date stated above.

ADDRESS (Street, city or town, state)

DATE SIGNED

ACTUAL
SIGNATURE

H. C. Alschl

M.D.

Frostburg, Md. 4/26/57

PHYSICIAN'S
NAME (Type)

John B. Davis, M. D.

Frostburg, Md.

22a. BURIAL, CREMATION,
REMOVAL (Specify)

22b. DATE THEREOF

22c. NAME OF CEMETERY OR CREMATORI

22d. LOCAT ON (City, town, or county)

(State)

Burial

4-27-57

F'bg. Memorial Park

Frostburg, Md.

23. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

J. R. Durst, Frostburg, Md.

24a. REC'D BY REGISTRAR

24b. REG STAR'S SIGNATURE

DATE 4-27-57

J. R. Durst, Frostburg, Md.

RECEIVED
BUREAU V. A.

AY 2 1957

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03593

3566

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH a. COUNTY Allegany		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Allegany		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 45 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		d. STREET ADDRESS 302 Cumberland St.		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 302 Cumberland St.						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)	First Mary	Middle Elizabeth	Last Stegmaier	4. DATE OF DEATH April 17	Month April	Day 17	Year 1957	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH March 7, 1877	9. AGE (In years last birthday) 80	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	12. IF UNDER 24 HRS. Hours 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Elk Garden, W. Va.		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Edward Kelley				14. MOTHER'S MAIDEN NAME Mary Melody				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Mr. Harry I. Stegmaier, Cumberland, Md.		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ovarianomatosis DUE TO 199.9 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)								
INTERVAL BETWEEN ONSET AND DEATH								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from March , 1957, to 4/17 , 1957, that I last saw the deceased alive on 4/17 , 1957, and that death occurred at 10 A.M. from the causes and on the date stated above.								
ACTUAL SIGNATURE <i>Leo H. Ley Jr.</i>		M.D.		ADDRESS (Street, city or town, state) 487 N. Centre St.		DATE SIGNED 4/19/57		
PHYSICIAN'S NAME (Type) LEO H. LEY JR.		22a. BURIAL, CREMATION, REMOVAL (Specify) Burial						
22b. DATE THEREOF 4-22-57		22c. NAME OF CEMETERY OR CREMATORIAL SS. Peter & Paul		22d. LOCATION (City, town, or county) Cumberland, Md.		(State)		
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS James F. Scarpelli, Cumberland, Md.								
24a. REC'D. BY REGISTRAR Philip J. Frank M.D.		24b. REGISTRAR'S SIGNATURE Philip J. Frank M.D.						

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the Burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. A.

APR 21 1957

REGELIVEL

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
 page 3 should be attached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3598

CERTIFICATE OF DEATH

13594

Reg. Dist. No. 8

1. PLACE OF DEATH a. COUNTY Allegany		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Midland		c. LENGTH OF STAY IN lb 59 yrs	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Earl	Middle B.	Last Steidling
4. DATE OF DEATH	Month April	Day 3	Year 1957
5. SEX	6. COLOR OR RACE Male	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/21/1889
9. AGE (In years last birthday) 67 yrs	10. IF UNDER 1 YEAR Months 67	11. IF UNDER 24 HRS DAYS Hours	12. IF UNDER 24 HRS Min. 00
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist		10b. KIND OF BUSINESS OR INDUSTRY Celanese Corp	
10c. BIRTHPLACE (State or foreign country) Elk Garden, W.Va.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John E. Steidling		14. MOTHER'S MAIDEN NAME Elizabeth McLaughlin	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO 214-07-3803	
17. INFORMANT John Steidling		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause lost. (b) DUE TO Diabetes mellitus (c)	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20. INTERVAL BETWEEN ONSET AND DEATH 30 min.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	Day Not white at work <input type="checkbox"/> of work <input type="checkbox"/>	20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/>
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Lonaconing	(County) Md.	(State) Md.
21. I certify that I attended the deceased from July , 1956, to April , 1957, that I last saw the deceased alive on April 3 , 1957, and that death occurred at 1 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Main St			
ACTUAL SIGNATURE <i>Leslie R. Miles</i>	DATE SIGNED 4.5.57		
PHYSICIAN'S NAME (Type) LESLIE R. MILES JR.	22. BURIAL, CREMATION, REMOVAL (Specify) Burial		
22b. DATE THEREOF 4/6/57	22c. NAME OF CEMETERY OR CREMATORIAL I.O.O.F Cemetery	22d. LOCATION (City, town, or county) Elk Garden	(State) W.Va.
23. FUNERAL DIRECTOR'S SIGNATURE George Eichhorn	ADDRESS Lonaconing, Md.	24a. REC'D. BY REGISTRAR DATE 4/6/57	24b. REGISTRAR'S SIGNATURE Jeanette M. Bost

RECEIVED
BUREAU V. S.

APR 11 1957

Outside of
General
Hospital

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 1
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it may be used as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3599

CERTIFICATE OF DEATH

03595
4

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL and give nearest town Rural Cumberland		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Cumberland		d. STREET ADDRESS R.D. # 1, Box 306			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION R.D. # 1, Box 306						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Dorothy		First	Middle	Last	4. DATE OF DEATH April 15,	Month	Day	Year 19 57	
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 9, 1879	9. AGE (In years last birthday) 77 yrs	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days	12. IF UNDER 24 HRS Hours	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) McKeey sport, Penna.		12. CITIZEN OF WHAT COUNTRY? U.S.			
13. FATHER'S NAME Herman Heeren		14. MOTHER'S MAIDEN NAME Stella Roth		Address					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs. Henry Dempsey		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 151X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. DUE TO (b) Cardit renal vascular disease (c) Generalized arterio sclerosis			19. INTERVAL BETWEEN ONSET AND DEATH 2 yrs
									19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>—</u> 19 p. m. <u>—</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not white at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) At I. Hall Hwy, Cumberland, Md.		(County) <u>—</u> (State) <u>—</u>	
21. I certify that I attended the deceased from <u>April 15</u> , 1957, to <u>April 15</u> , 1957, that I last saw the deceased alive on <u>April 15</u> , 1957, and that death occurred at <u>1:30 P.M.</u> from the causes and on the date stated above. ACTUAL SIGNATURE <u>cycle R. Everhart</u> M.D.		ADDRESS (Street, city or town, state) At I. Hall Hwy, Cumberland, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF Apr. 18, 1957		22c. NAME OF CEMETERY OR CREMATORIUM Allegheny Cem.		22d. LOCATION (City, town, or county) Pittsburgh, Penna.			
23. FUNERAL DIRECTOR'S SIGNATURE CHARLES L. GEORGE		ADDRESS Cumberland, Maryland.		24a. REC'D BY REGISTRAR April 18, 1957		24b. REGISTRAR'S SIGNATURE W. L. Frantz, M.D.			

REGEV

ADP 17 1957

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3600

CERTIFICATE OF DEATH

Reg. Dist. No. 03596

1. PLACE OF DEATH a. COUNTY Allegany		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Md.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural-Westernport		c. LENGTH OF STAY IN 1b 64 Yrs	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1 Mi. N. Westernport		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westernport-Rural	
3. NAME OF DECEASED (Type or print) Elmer		First Lee	Middle Trenum
4. DATE OF DEATH April		Month	Day Year 22 1957.
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 11, 1892
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Janitor		10b. KIND OF BUSINESS OR INDUSTRY Bakery	11. BIRTHPLACE (State or foreign country) Westernport, Md
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Jefferson Trenum	
14. MOTHER'S MAIDEN NAME Katherine McManus		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no	
16. SOCIAL SECURITY NO 212-12-8111		17. INFORMANT William Trenum-Westernport, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 415X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 16 months Rheumatic Fever 56 Years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) None	
20c. TIME OF INJURY Hour o. m. p. m.	Month 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) M.D.
21. I certify that I attended the deceased from <u>Jan. 26</u> , 1957, to <u>Apr. 22</u> , 1957, that I last saw the deceased alive on <u>Apr. 27</u> , 1957, and that death occurred at <u>8:35 P.M.</u> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) M.D. <u>Washfield St. Edmenton Md.</u> DATE SIGNED <u>4-24-17</u>	
ACTUAL SIGNATURE <u>Paul R. Wilson</u>		PHYSICIAN'S NAME (Type) <u>Paul R. Wilson M.D.</u>	
22a. BURIAL, CREMATION, OR REMOVAL (Specify) Burial	22b. DATE THEREOF 4/25/57	22c. NAME OF CEMETERY OR CREMATORIAL Philos	22d. LOCATION (City, town, or county) Westernport
23. FUNERAL DIRECTOR'S SIGNATURE <u>E.S. Kelly</u>		ADDRESS Westernport, Md.	24a. REC'D BY REGISTRAR DATE 4-25-57
			24b. REGISTRAR'S SIGNATURE <u>John C. Kelly</u>

BUREAU V. 8

APR 29 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of the death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please ~~remove carbon paper~~ Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3601

CERTIFICATE OF DEATH

Reg. Dist. No. 08597

1. PLACE OF DEATH a. COUNTY Allegany		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lonaconing		c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lonaconing	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Jackson Street		d. STREET ADDRESS Jackson Street	
3. NAME OF DECEASED (Type or print) Frank		First Frank	Middle
Last Trost		4. DATE OF DEATH April 13 1957	Month April
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH August 15, 1898		9. AGE (in years last birthday) 58 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Baker		10b. KIND OF BUSINESS OR INDUSTRY Carver Hall	
11. BIRTHPLACE (State or foreign country) Lonaconing, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME August H. Trost		14. MOTHER'S MAIDEN NAME Dora Finkeldey	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO 213-16-9896	
17. INFORMANT Werner C. Trost		Address Lonaconing, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)		"Brother" Coronary Occlusion Arteriosclerosis Diabetes Mellitus	
		INTERVAL BETWEEN ONSET AND DEATH years	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Dec 1955 to April 1957 , and that I last saw the deceased alive on April 12 1957 , and that death occurred at 5:45 P.M. from the causes and on the date stated above. ACTUAL SIGNATURE Leslie R. Miles, M.D.		ADDRESS (Street, city or town, state) Main St. Lonaconing Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/15/57	
22c. NAME OF CEMETERY OR CREMATORIAL St. Luke's Cemetery		22d. LOCATION (City, town, or county) Cumberland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE George Eichhorn		ADDRESS Lonaconing, Md.	
24a. REC'D. BY REGISTRAR DATE 4/15/57		24b. REGISTRAR'S SIGNATURE Jeanette M. Doel	

RECEIVED
BUREAU X-4
MAY 19 1957

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03598

DR. MURRAY

3567

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH a. COUNTY ALLEGANY		2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		b. COUNTY ALLEGANY	
c. LENGTH OF STAY IN 1b 1 DAY		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL		d. STREET ADDRESS 1202 PIEDMONT AVENUE	

3. NAME OF DECEASED (Type or print) George	First & Middle Chester	Last VALENTINE	4. DATE OF DEATH APRIL 7 1957	Month Day Year
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S. SEX MALE	16. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH JANUARY 4, 1900	9. AGE (in years last birthday) 57 yrs.	10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FURNITURE REPAIRMAN & UPHOLSTERER		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) CUMBERLAND, MD.	12. CITIZEN OF WHAT COUNTRY? U.S.A.		
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13. FATHER'S NAME ABRAHAM VALENTINE	14. MOTHER'S MAIDEN NAME REBECCA ROMIG	Address
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? No	16. SOCIAL SECURITY NO. 214-32-2895	17. INFORMANT MEMORIAL HOSPITAL - CUMBERLAND, MD.
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)	INTERVAL BETWEEN ONSET AND DEATH 2 weeks
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.	
(b) Hypertension	one month
DUE TO Deabetes	several years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)	

20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)

21. I certify that I attended the deceased from <u>1950</u> , <u>1957</u> to <u>April 6, 1957</u> , <u>1957</u> that I last saw the deceased alive on <u>April 6, 1957</u> , and that death occurred at <u>1:30 A.M.</u> from the causes and on the date stated above.	ADDRESS (Street, city or town, state)	DATE SIGNED 4/8/57
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ACTUAL SIGNATURE DR. F. A. G. MURRAY	PHYSICIAN'S NAME (Type)
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22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 4/10/57	22c. NAME OF CEMETERY OR CREMATORIAL Hillcrest Burial Park	22d. LOCATION (City, town, or county) Cumberland, Maryland	(State)
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23. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer, Cumberland, Maryland	ADDRESS	24a. REC'D BY REGISTRAR DATE: 4/11/1957	24b. REGISTRAR'S SIGNATURE Dr. F. A. G. Murray, M.D.
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BUREAU V. S

1PR 12 1957

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
3563 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

03599

1. PLACE OF DEATH a. COUNTY Allegany		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) b. STATE Md. c. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN lb 7 hrs.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Memorial Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) x2 Old Town	
3. NAME OF DECEASED (Type or print) Loy		First James	Middle Wagner
4. DATE OF DEATH Month April		Day 28	Year 19 57
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 8-1944
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		10b. KIND OF BUSINESS OR INDUSTRY School	11. BIRTHPLACE (State or foreign country) Cumberland, Md.
13. FATHER'S NAME Bruce C. Wagner		14. MOTHER'S MAIDEN NAME Dorothy Nethers	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	17. INFORMANT (father) Bruce C. Wagner
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Address INTERVAL BETWEEN ONSET AND DEATH 7.2 hrs	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		Intra-abdominal hemorrhage	
DUE TO (c)		Fractured pelvis & bronchial hemorrhage	
		congestion of lungs, also fracture left femur	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH. Driver lost control of car & hit a tree in W.Va.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour 8 - April 27 57 9.15 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Highway, near Green Spring W. Va.
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>		22. MEDICAL CERTIFICATION	
ACTUAL SIGNATURE H. V. Deming K.D.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> April 28-1957	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF April 30, 1957	22c. NAME OF CEMETERY OR CREMATORIUM Oldtown Cemetery
22d. LOCATION (City, town, or county) Oldtown, Maryland		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer, Cumberland, Maryland.		24a. REC'D BY REGISTRAR April 29, 1957 W.L. Hanley, M.D.	
ADDRESS John J. Hafer, Cumberland, Maryland.		24b. REGISTRAR'S SIGNATURE	

RECEIVED
BUREAU V. S.

APR 30 1957

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3692

CERTIFICATE OF DEATH

03600

Reg. Dist. No. 6

1. PLACE OF DEATH o COUNTY Allegany		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) o STATE Md.		b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Luke		c. LENGTH OF STAY IN lb 8 yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) x 2. Luke			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 125 Cromwell		d. STREET ADDRESS 125 Cromwell		e. IS RESIDENCE ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Wright		First Montgomery	Middle Welton	4. DATE OF DEATH April	Month 5	Day 1957	Year
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH July 31, 1895	9. AGE (In years last birthday) 61 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days	12. IF UNDER 24 HRS Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chemist		10b. KIND OF BUSINESS OR INDUSTRY Paper Mill		11. BIRTHPLACE (State or foreign country) W. Va.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Sanford Welton		14. MOTHER'S MAIDEN NAME Daisy Davis		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or dates of service) Yes W. W. I			
16. SOCIAL SECURITY NO. (If not, give name or dates of service)		17. INFORMANT 109-01-4647 Mrs. Harriette Welton-Luke, Md		Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4x d.1 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last		DUE TO Corebral Hemorrhage		INTERVAL BETWEEN ONSET AND DEATH 12 Hours			
(b) DUE TO Chronic Myocarditis				7 Years			
(c) Arterio-sclerosis				7 Years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) None					
20c. TIME OF INJURY Month, Doy, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While Not while of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Apr. 4</u> , 1957, to <u>Apr. 5</u> , 1957, that I last saw the deceased alive on <u>Apr. 4</u> , 1957, and that death occurred at <u>5:55 A.M.</u> from the causes and on the date stated above.		ACTUAL SIGNATURE Paul B. Wilson		M.D.		ADDRESS (Street, city or town, state) Piedmont, W. Va.	
22a. BURIAL, CREMATION, OR REMOVAL (Specify) Burial		22b. DATE THEREOF 4/8/57		22c. NAME OF CEMETERY OR CREMATORIUM Philos Cem.		22d. LOCATION (City, town, or county) Westernport	
23. FUNERAL DIRECTOR'S SIGNATURE E. B. Wilson		ADDRESS Westernport, Md.		24a. REC'D BY REGISTRAR DATE 4-8-57		24b. REGISTRAR'S SIGNATURE Jean C. Kelly	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the Burial-Transit Permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

APR 9 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3569 CERTIFICATE OF DEATH

03601

Reg. Dist. No. 4

Within corporate limits

TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that this death certificate be executed within 24 hours after death. Please retain by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-tranit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the register prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Allegany		2. USUAL RESIDENCE (Where deceased lived) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Rural Cumberland	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Sacred Heart hospital		d. STREET ADDRESS Route #2 Baltimore Pike	
3. NAME OF DECEASED (Type or print) JOHN		4. DATE OF DEATH Month April 17 Year 1957	
5. SEX Male		6. COLOR OR RACE White	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH 1/24/79	
9. AGE (In years last birthday) 78 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman		10b. KIND OF BUSINESS OR INDUSTRY Self-employed	
11. BIRTHPLACE (State or foreign country) Indiana		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 045-16-6683	
17. INFORMANT Rt. 2, Baltimore Pike Mrs. Dorothy N. White, Cumberland, Maryland		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) IX DUE TO Cerebral hemorrhage INTERVAL BETWEEN ONSET AND DEATH 3 days	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO (c)		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Apr 14, 1957</u> to <u>Apr 17, 1957</u> , that I last saw the deceased alive on <u>Apr 16, 1957</u> , and that death occurred at <u>4:30 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) ACTUAL SIGNATURE <u>R. W. Trevaskis, Sr.</u> M.D. <u>Cumberland, Md.</u> DATE SIGNED <u>4/18/57</u>			
PHYSICIAN'S NAME (Type) R. W. Trevaskis, Sr. I.D. 220 Baltimore Avenue, Cumberland, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/19/57	
22c. NAME OF CEMETERY OR CREMATORIAL Frostburg Memorial Park		22d. LOCATION (City, town, or county) (State) Frostburg, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer, Cumberland, Maryland		24a. REG'D BY REGISTRAR DATE <u>Apr 19, 1957</u>	
		24b. REGISTRAR'S SIGNATURE <u>W. L. Frank, M.D.</u>	

BUREAU V.

APR 24 1967

REGELVET

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3579

CERTIFICATE OF DEATH

Reg. Dist. No.

03602

1. PLACE OF DEATH a. COUNTY ALLEGANY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 1 DAY	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL		e. STREET ADDRESS 128 HANOVER STREET	
3. NAME OF DECEASED (Type or print) FRED		First W.	Middle WIEBEL
4. DATE OF DEATH APRIL 12 1957	Month APRIL	Day 12	Year 1957
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 4 1885
9. AGE (In years last birthday) 72 yrs		10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED STATE POLICE Worker State Motor		10b. KIND OF BUSINESS OR INDUSTRY Vehicle Office	11. BIRTHPLACE (State or foreign country) MARYLAND
13. FATHER'S NAME JOHN WIEBEL		14. MOTHER'S MAIDEN NAME ELIZABETH SCHNEIDER	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. None	17. INFORMANT Address MEMORIAL HOSPITAL, CUMBERLAND, MARYLAND
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myocardial Infarction DUE TO 40000 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last Coronary Insufficiency DUE TO (b) Coronary Insufficiency DUE TO (c) Atherosclerotic Heart Disease INTERVAL BETWEEN ONSET AND DEATH 31 Hours			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Generalized Atherosclerosis			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <input type="checkbox"/> a.m. 19 <input type="checkbox"/> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) — (County) (State)
21. I certify that I attended the deceased from 4/11/57 , 19 57 , to 4/12 , 19 57 , that I last saw the deceased alive on 4/12 , 19 57 , and that death occurred at 8:27 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 54 Greene St DATE SIGNED 4/13/57			
ACTUAL SIGNATURE S.G. WEISMAN, MD.			
22a. FOR AL. CREMATION REMOVAL (Specify) Burial		22b. DATE THEREOF Apr. 15, 1957	22c. NAME OF CEMETERY OR CREMATORIAL Rose Hill Cem.
22d. LOCATION (City, town, or country) Cumberland MD		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE Louis Stein Inc		24a. ADDRESS Cumberland MD	24b. REG'D. BY REGISTRAR April 15, 1957
		REGISTRAR'S SIGNATURE W.H. Frank, M.D.	

RECEIVED
APR 1 1968

URÉAU V. S

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03603

CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH
a. COUNTY

Allegany

MARYLAND

2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland
b. COUNTY Allegany

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Frostburg

c. LENGTH OF STAY IN 1b

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Frostburg

d. NAME OF HOSPITAL (If not in hospital, give street address)
OR INSTITUTION

91 Broadway

d. STREET ADDRESS

91 Broadway

e. IS RESIDENCE
ON A FARM?
YES NO 3. NAME OF
DECEASED
(Type or print)First
LOUISAMiddle
A.Last
WILLIAMS4. DATE
OF
DEATHMonth
AprilDay
20, 1957
Year

5. SEX

female

6. COLOR OR RACE

white

7. MARRIED NEVER MARRIED WIDOWED DIVORCED

8. DATE OF BIRTH

Jan. 14, 1864

9. AGE (In years
lost birthday)93
yrs

10. IF UNDER 7 YEAR

Months

11. IF UNDER 24 HRS

Days

Hours

Min

10a. USUAL OCCUPATION (Give kind of work done
during most of working life, even if retired)

housewife

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

John Hansel

14. MOTHER'S MAIDEN NAME

Harriet Troutman

15. WAS DECEASED EVER IN U. S. ARMED FORCES?

(Yes or no or unknown)

16. SOCIAL SECURITY NO.

(If yes, give war or dates of service)

17. INFORMANT

none

Mrs. Louis Sluss, Frostburg, Md.

Address

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))

PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a)

450.0

DUE TO

Conditions, if any, which
gave rise to immediate
cause (a), stating the under-
lying cause last

(b)

DUE TO

(c)

Arterio Sclerosis
SenilityINTERVAL BETWEEN
ONSET AND DEATH
Seven years

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH
(If either, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Month, Day, Year
Hour o. m. 19
p. m.20d. INJURY OCCURRED
While Not while
of work at work 20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I attended the deceased from June 24, 1957, to April 20, 1957, that I last saw the deceased
alive on May 30, 1957, and that death occurred at M. from the causes and on the date stated above.

ADDRESS (Street, city or town, state)

DATE SIGNED

ACTUAL
SIGNATURE

W. O. McLane, M. D.

Frostburg

Apr
22 195722a. BURIAL, CREMATION,
REMOVAL (Specify)

Burial

22b. DATE THEREOF

4-22-57

22c. NAME OF CEMETERY OR CREMATORY

F'bg. Memorial Park

22d. LOCATION (City, town, or county)

Frostburg, Md.

(State)

23. FUNERAL DIRECTOR'S SIGNATURE

J. R. Durst, Frostburg, Md.

ADDRESS

24a. REC'D BY REGISTRAR

DATE

24b. REGISTRAR'S SIGNATURE

Apr
22 1957
Mrs Nancy N. Ross

BUREAU Y.

53 5 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03604

Reg. Dist. No. 4

3571

1. PLACE OF DEATH
a. COUNTY

Allegany

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Cumberland

c. LENGTH OF STAY IN 16

7 yrs.

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

Sylvan Retreat

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)

a. STATE Md.

b. COUNTY Allegany

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Mt. Savage

d. STREET ADDRESS

/

e. IS RESIDENCE
ON A FARM?
YES NO 3. NAME OF
DECEASED
(Type or print)First
John

Middle

Last
Willison4. DATE
OF
DEATHMonth April
Day 13
Year 1957

5. SEX

male

6. COLOR OR RACE

white

7. MARRIED NEVER MARRIED WIDOWED DIVORCED

8. DATE OF BIRTH

Dec. 25 1878

9. AGE (In years
for birthday)

78 yrs.

10. IF UNDER 1 YEAR

Months

11. IF UNDER 24 HRS.

Days

12. IF UNDER 24 HRS.

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work done
during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (If
foreign country)

12. CITIZEN OF WHAT COUNTRY?

Retired laborer-Cumberland Incinerator

Gilpin, Md.

U.S.A.

13. FATHER'S NAME

Isiah Willison

14. MOTHER'S MAIDEN NAME

Hannah Robinette

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unknown)

No

16. SOCIAL SECURITY NO.

17. INFORMANT

Address

Sylvan Retreat records

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY,
IMMEDIATE CAUSE (a)

Generalized arteriosclerosis

about 7 yrs

450.0

DUE TO

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

(b)

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY
PERFORMED?
YES NO

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS
PRIMARY or CONTRIBUTING CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY
Month, Day, Year
Hour
a. m.
p. m.20d. INJURY OCCURRED
While
at work Not while
at work 20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I took charge of the remains described above, held an Autopsy , Inspection , Inquiry , and find that
death resulted from: Natural causes , Accident , Suicide , Homicide , Undetermined cause .ACTUAL
SIGNATURE

H. V. Denning M.D.

M.D. CHIEF MEDICAL EXAMINER ASSISTANT MEDICAL EXAMINER DEPUTY MEDICAL EXAMINER

April 13-1957

22a. BURIAL, CREMATION,
REMOVAL (Specify)

Burial

22b. DATE THEREOF

April 15, '57

22c. NAME OF CEMETERY OR CREMATORIUM

I.O.O.F. Cemetery

22d. LOCATION (City, town, or county)

(State)

Flintstone, Md.

23. FUNERAL DIRECTOR'S SIGNATURE

John J. Hafer, Cumberland, Maryland

ADDRESS

24a. REGD BY REGISTRAR

DATE

24b. REGISTRAR'S SIGNATURE

April 15, 1957 H. V. Denning M.D.

DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. ATSMES(S)
SM 9/55

SUREAU V. S

RECEIVED

APR 12 1968

03605

4

Reg. Dist. No.

3572

CERTIFICATE OF DEATH

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY ALLEGANY				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE PENNSYLVANIA	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN lb 17 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ALIQUIPPA	
d. NAME OF HOSPITAL (If deceased died in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL MEMORIAL & WARWICK AVES.,				d. STREET ADDRESS 231 HOPEWELL AVENUE	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) VIRGINIA		First Susan	Middle S	Last WILSON	4. DATE OF DEATH APRIL 13 1957
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH NOVEMBER 25, 1908	9. AGE (In years last birthday) 40 yrs.	IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0
8. WIDOWED <input type="checkbox"/>		DIVORCED <input type="checkbox"/>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		
10b. KIND OF BUSINESS OR INDUSTRY Own home		11. BIRTHPLACE (State or foreign country) W. VA. Wardensville			12. CITIZEN OF WHAT COUNTRY? U. S.
13. FATHER'S NAME William M. LANDACRE			14. MOTHER'S MAIDEN NAME MAE V. Rummel		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No,		16. SOCIAL SECURITY NO. None		17. INFORMANT Luther W. Wilson 231 Hopewell Ave., Aliquippa, Penna.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Nitral Stenosis DUE TO 410X					
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. [Enter nature of injury in Part I or Part II of item 18.]			
20c. TIME OF INJURY Hour o. m. p. m.	Month 19	Day	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 3/27 1957 to 4/13 1957 , that I last saw the deceased alive on 4/13 1957 , and that death occurred at 2:30 P.M. from the causes and on the date stated above.					
ACTUAL SIGNATURE <i>Leo H. Ley Jr.</i>	ADDRESS (Street, city or town, state) 456 N. Centre St Cumberland, Md.				DATE SIGNED 4/14/57
PHYSICIAN'S NAME (Type) LEO H. LEY JR.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 4/16/57	22c. NAME OF CEMETERY OR CREMATORIUM Wardensville Cem.	22d. LOCATION (City, town, or county) Wardensville, W. Va. (State)		
23. FUNERAL DIRECTOR'S SIGNATURE H. Wayne George			ADDRESS Cumberland, Md.	24a. REC'D. BY REGISTRAR April 6, 1957	24b. REGISTRAR'S SIGNATURE W. Frank M.

CHARGE OF DATA

BUREAU V. S.

APR 10 1968

RECEIVED

Outside of
Lima
M
Rural
00

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please do so in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar prior to removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

36 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03606
4

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		d. STATE P a. b. COUNTY Somerset	
Cumberland		23 yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
Celanese dispensory		Wellersburg 75x-5			
3. NAME OF DECEASED (Type or print)		First Joseph	Middle Charles	Last Wingert	4. DATE OF DEATH April Month Day Year 8 1957
5. SEX male		6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH April 7-1916	9. AGE (In years last birthday) 47 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY Celanese Corp.		11. BIRTHPLACE (State or foreign country) Wellersburg, Pa.	
13. FATHER'S NAME Walter Wingert		14. MOTHER'S MAIDEN NAME Eleanor Shaffer		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? [Yes, no, or unknown] Yes		16. SOCIAL SECURITY NO. W.W. 2		17. INFORMANT Ada King, Mt. Savage Road, Cumberland, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		Address			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1		Coronary occlusion			
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH sudden			
(b)		Coronary sclerosis			
DUE TO (c)		?			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. p. m.		Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .		DATE SIGNED			
ACTUAL SIGNATURE H. V. Deming M.D.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> April 9-1957			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF April 11, 1957		22c. NAME OF CEMETERY OR CREMATORIUM Wellersburg Lutheran Cem.	22d. LOCATION (City, town, or county) Wellersburg, Pennsylvania (State)
23. FUNERAL DIRECTOR'S SIGNATURE Harvey H. Zeigler, Hyndman, Pennsylvania.		ADDRESS		24a. REC'D. BY REGISTRAR April 10, 1957	24b. REGISTRAR'S SIGNATURE W. L. Frantz M.D.

BUREAU V. S

APR 11 1967

REGEL V ELL